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ABSTRACT

Human Immunodeficiency Virus (HIV) is a serious health problem in the United States and in the world. To date, there is no vaccine to protect people from HIV infection, nor is there a cure for those who are infected and are facing the consequences of this life-threatening disease. But infection with HIV can be prevented if people know and avoid the specific behaviors that put them at risk; therefore, education is the most effective weapon we have to combat this deadly virus. This manual was completed by the National School Boards Association for the Program on School Health Education To Prevent the Spread of HIV. Designed to assist workshop leaders in preparing and presenting workshops for school board members on developing and implementing HIV education programs for youth, it provides activities and resources that will: (1) clarify for board members the role and responsibility of schools in providing HIV education; and (2) help board members gain skills for managing controversy surrounding HIV youth education. The seven sections comprising this document feature an introduction; detail the steps of planning, presenting, and evaluating the workshop; list resources; and provide a participant notebook and transparencies. In May 1988, the workshop curriculum was field-tested with a group of school board members with cooperation from the Virginia School Boards Association. The curriculum was refined based on that experience and on evaluation by a sample of state boards associations staff. (KM)

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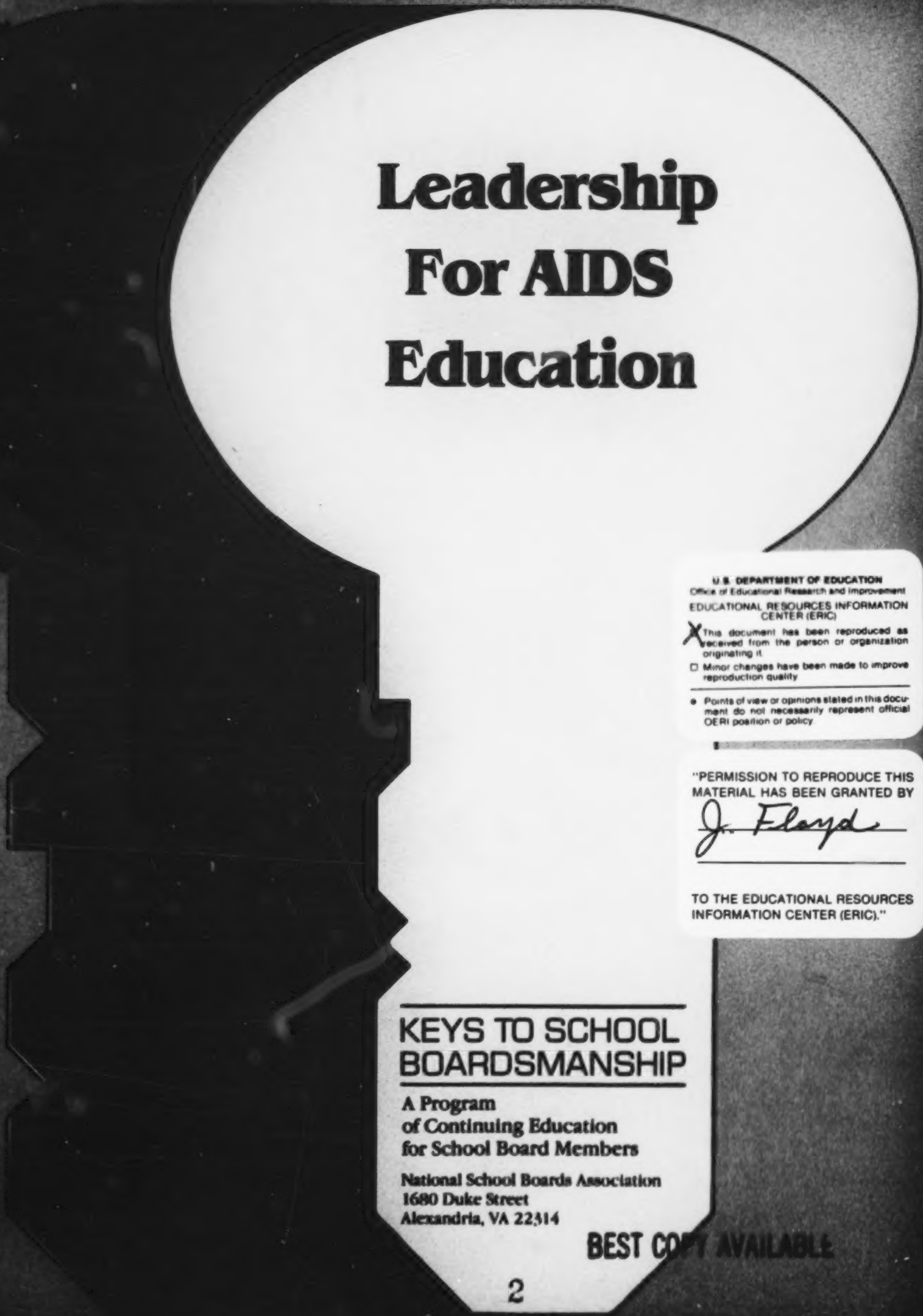

Leadership For AIDS Education

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KEYS TO SCHOOL BOARDSMANSHIP

A Program
of Continuing Education
for School Board Members

National School Boards Association
1680 Duke Street
Alexandria, VA 22314

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LEADERSHIP FOR PUBLIC EDUCATION

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FOREWORD

This manual has been developed by the National School Boards Association (NSBA) with support provided by a cooperative agreement with the Division of Adolescent and School Health, Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control (CDC). It is a tool to provide continuing education for local school board members that results in local leadership for school-based education of youth to prevent the spread of infection with the human immunodeficiency virus (HIV). The format and substance of this manual parallel the "Keys to School Boardsmanship" series, which is published and distributed by NSBA.

The workshop curriculum provided in this manual was field-tested in May, 1988, with a group of school board members with cooperation from the Virginia School Boards Association. It was refined based on that experience and on evaluation by a sample of staff from state school boards associations. The manual is being disseminated to NSBA Federation Member state school boards associations and to the AIDS coordinators of all state education departments, state health departments, and of those local education agencies and national organizations that have cooperative agreements with the CDC.

All the materials contained in this manual were reviewed by staff of the CDC and by the NSBA AIDS Education Project Advisory Committee, which included representatives of school boards, administrators, school boards associations, health educators, teachers, and parents. The Advisory Committee was composed of:

- Rexene Ashford, Immediate Past President, New York State School Boards Association
- Wayne Blanton, Executive Director, Florida School Boards Association
- Constance Clayton, Superintendent, School District of Philadelphia
- Brian Dale, American Federation of Teachers
- Jacob Gayle, AIDS Task Force, American School Health Association
- James Oglesby, President Elect, National School Boards Association
- Manya Ungar, President, The National PTA.

In addition, the American Association of State Policy Services was consulted through Richard Funk, then president of the association and assistant executive director, Kansas Association of School Boards. Staff of many NSBA Federation Member state school boards associations supported this project through solicitation and submission of resource materials.

Also, the fieldtest faculty were of immeasurable assistance in developing and refining these materials and are gratefully acknowledged: Susan Thorner, AIDS Health Educator, Virginia Department of Health; Edward Brickell, consultant and former superintendent, Virginia Beach (Va.) Public Schools; Richard Keeling, M.D., Director of the Department of Student Health, University of Virginia, Charlottesville. Appreciation also is extended to Rebecca Reeve, University of Virginia, for providing useful materials and sound advice, and to Laura Abraham, The National PTA, and Herbert Hazan, School District of Philadelphia, for their guidance.

We trust that you will discover the practical value of these materials. With the continued support of the CDC, NSBA will provide updated and additional materials to supplement this manual.

Very truly yours,

Leonard Rovins
President

Thomas A. Shannon
Executive Director

PREFACE

In its June 1988 report, the Presidential Commission on the Human Immunodeficiency Virus reflected a growing consensus by stating:

> The term "AIDS" is obsolete. "HIV infection" more correctly defines the problem. The medical, public health, political, and community leadership must focus on the full course of HIV infection rather than concentrating on later stages of the disease (ARC and AIDS). Continual focus on AIDS rather than the entire spectrum of HIV disease has left our nation unable to deal adequately with the epidemic.

In spite of the Commission statement, a conscious decision was made to retain the term "AIDS" in the title of this manual. In just a few short years, "AIDS," which stands for acquired immunodeficiency syndrome, has become part of our everyday vocabulary. It is the term used by the mass media, and continues to be used in public education campaigns such as the U.S. Department of Health and Human Services' campaign, America Responds to AIDS.

Nevertheless, it is not too soon to begin educating students and the public about the difference between HIV, HIV infection, and AIDS. These are three key terms that should not be used synonymously or interchangeably. They are defined as follows:

HIV: The name of the organism (germ) -- human immunodeficiency virus.

HIV infection: The state of being infected with HIV. Development of antibody to HIV is clear-cut evidence of infection with the virus.

AIDS: The clinical term for the severe condition that frequently results from years of HIV infection and often is life-threatening.

The content of this manual attempts to reflect these definitions. For example, AIDS education is referred to as HIV education; the AIDS virus is referred to as HIV. Exceptions to this guideline are made in quoted materials, primarily in Section 5 (Resources), which includes previously published materials.

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SECTION 1: INTRODUCTION

Purpose and Rationale

Leadership for AIDS Education is a manual designed to assist workshop leaders in preparing and presenting workshops for school board members on developing and implementing HIV education programs for youth. Through the activities and resources provided in this manual, school board members will gain an understanding of the need and purpose of HIV education and develop skills for implementing HIV education programs in their schools. The underlying philosophy put forward in this training program is that HIV education, in keeping with local community needs and values, will enable youth to protect themselves from infection with the human immunodeficiency virus (HIV).

HIV infection is a serious public health problem in the United States and in the world. To date, there is no vaccine to protect people from HIV infection; nor is there a cure for those who are infected and are facing the consequences of this life-threatening disease. But infection with HIV can be prevented if people know and avoid the specific behaviors that put them at risk. Education is the most effective tool for ensuring that people know how to protect themselves. It also is the most effective tool for addressing unwarranted fear regarding HIV infection and AIDS.

There is general agreement among those in the forefront of the battle against the spread of HIV (including Surgeon General C. Everett Koop, the Centers for Disease Control, the Public Health Service, and the Presidential Commission on the Human Immunodeficiency Virus Epidemic) that it is of particular importance to educate young people who may experiment with or practice behaviors that put them at risk of infection. HIV infection results from sexual intercourse or the sharing of needles with an infected person. Before or during birth, HIV may be passed from an infected mother to her baby.

Education about HIV, therefore, involves discussion of sex, sexuality, and illicit drug use. These subjects are integral to education about good health practices and disease prevention. They also relate, however, to personal values about right and wrong. School programs that address these subjects may be viewed as interfering with or undermining the role of the family in teaching children about their sexuality and responsible behavior.

In the context of differing values and views about who will be taught, what will be taught, and who will teach it, school boards may find themselves immersed in controversy as they seek to provide school-based education to prevent the spread of HIV. School board members need information and skills that will be useful to them in planning and implementing HIV education programs with a minimum of controversy and a maximum of school community support.

Uses

Leadership for AIDS Education has several possible uses. It has been designed primarily as a tool for planning and presenting workshops that develop the awareness of school board members about the possibilities and processes for developing and implementing effective school-based HIV education. It could easily be adapted, however, for use with teams from several school districts (board members, administrators, teachers, parents) or with a school board or team from one community.

Goals and Objectives

The overall goal of this training program is to provide board members with the information and leadership skills they need to establish HIV education in schools. The specific objectives for the program are to:

- Help board members understand the value of education for preventing the spread of HIV, dispelling fears, and nurturing compassion and support for people infected with HIV.
- Clarify for board members the role and responsibility of schools in providing HIV education.
- Provide board members with a process for developing and implementing HIV education in schools.
- Help board members develop their skills for managing controversy surrounding HIV education for youth.
- Provide board members with access to resources for developing and implementing HIV education.

Organization of the Manual

The remaining sections of this manual contain materials that the workshop faculty should review carefully before presenting this workshop.

Section 2: Planning the Workshop

This section contains information about preparations the faculty should make before presenting the workshop. Included are suggestions about:

- Becoming familiar with background materials;
- Physical arrangements for the workshop;
- Grouping of participants;
- Preparing materials for the workshop; and
- Equipment needed.

Section 3: Presenting the Workshop

Workshop faculty should carefully study this section. It serves as a lesson plan for conducting the workshop. Each workshop activity is described in detail, along with time allocation and references to participant materials and other resources used in the activity. You will find:

- A suggested sequence of workshop activities;
- Detailed instructions on how to conduct each activity;
- A leader focus for each activity; and
- Helpful hints about handling workshop activities.

Section 4: Evaluating the Workshop

Evaluation and feedback are important in developing the skills and perceptions of the workshop leader. In addition, because the primary goal of this workshop is to increase HIV education in schools, feedback regarding local actions resulting from the workshop experience is important. In this section, you will find:

- A rationale for workshop evaluation;
- Suggested uses of evaluation data;
- A discussion of the evaluation form for this workshop;
- An approach to measuring results of the workshop in affecting actions by local school boards.

Section 5: Resources

This section contains topical background material that the workshop faculty should read and assimilate before presenting the workshop. Here you will find:

- The Facts: Adolescents, AIDS, and the Human Immunodeficiency Virus (Center for Population Options)

- Criteria for Evaluating an AIDS Curriculum (National Coalition of Advocates for Students)

- "Certain Practices of School-Age Youth," excerpt from How Effective is AIDS Education? (Office of Technology Assessment, U.S. Congress)

- "Dealing with Controversy: The School Board Perspective" (NSBA presentation)

- Churches Call for Education on AIDS (National Council of the Churches of Christ)

In addition, at the back of this notebook, you will find some published materials that also should be read by the workshop faculty. These are:

- Surgeon General's Report on Acquired Immune Deficiency Syndrome (U.S. Department of Health and Human Services)

- Guidelines for Effective School Health Education to Prevent the Spread of AIDS (Centers for Disease Control)

- AIDS and the Education of Our Children: A Guide for Parents and Teachers (U.S. Department of Education)

Section 6: Participant Notebook

This section contains the camera-ready participant booklet or notebook designed for use in this workshop. Each workshop participant should be provided a copy of these materials. References to activities and briefing papers contained in the notebook are found in Section 3 of this manual (Presenting the Workshop).

This section also contains camera-ready copies of some of the workshop activities, including instructions for conducting the exercises. These materials may be provided to workshop participants in a separate packet for follow-up use in their communities.

Section 7: Transparencies:

This section contains prepared transparencies for use in this workshop. They are numbered to relate to the references contained in Section 3 of this manual (Presenting the Workshop).

SECTION 2: PLANNING THE WORKSHOP

In planning a workshop based on Leadership for AIDS Education, you will need to consider several issues and make important strategic decisions. The issues and some options are discussed in this section.

Scope of the Workshop

The HIV education workshop is designed for presentation in a single session of six hours (including two 15-minute breaks). It can be expanded by adding one or more of the optional activities provided or reduced by substituting a shorter optional activity for a core activity or by eliminating one or more activities. The length of a workshop also will be affected by how much time you spend with each activity and in discussion.

The workshop objectives can be adjusted in terms of the emphasis you wish to give to each. For example, more time might be given to managing controversy through role-playing practice for participants. Remember that good workshop practice requires that objectives be clear and attainable within the time available.

It also is important for the workshop leader to be able to explain to participants what the workshop is not going to cover. Although participants will learn accurate information about HIV infection, the workshop activities provided here are not designed to address the legal and policy issues related to employees or students who have been infected with HIV.

Workshop Faculty

The workshop format provided in this manual calls for a three-member faculty:

- A lead faculty member who is an expert in school board governance and is skillful in the areas of communications and public relations (suggested people for this role are staff from state school boards associations, board members, superintendents, and educational administration educators);
- A health educator who is knowledgeable about health education, school district curriculum practices, and HIV, and who is skillful in addressing people's feelings about sensitive issues (suggested people for this role are health educators associated with the state education department, state or local health department, local school districts, and universities);
- A medical professional who is authoritative, well informed about HIV infection, able to present technical information in language that is clear to lay people, and willing to be fully responsive to people's questions (suggested people for this role are state or local public health officials, members of medical societies, and medical experts recommended by public health officials).

Some activities provided in this manual can be presented by either the school governance expert or the health educator. Assignments should be based on the qualifications of the individuals selected as faculty. In addition, the workshop activities call for faculty who are skillful teachers of adults. They should be able to lecture, guide participants through activities, lead constructive and participatory discussions, respond effectively to participants' questions and comments, and show respect for diverse viewpoints.

Becoming Familiar with the Materials

The faculty will need to review and become familiar with several kinds of materials before presenting the workshop:

- Background Materials: These are found in Section 5 of the manual (Resources) and in the pocket inside the back cover of the notebook. They represent topical information relating to the workshop content. Reviewing these resources will help faculty become more familiar with the concepts and themes of the workshop.

- Workshop Procedures: These are outlined in detail in Section 3 (Presenting the Workshop). Faculty may wish to underline particular points to emphasize in the workshop. Alternatively, you may want to encourage faculty to write their own outline of workshop procedures to help them put ideas into their own words and to include examples from personal experience.

  You will note that each workshop activity is introduced by name and is followed by a Leader Focus. This statement of tone or purpose for the activity also may include suggestions about the pacing of the activity.

- Adding Materials: You may find materials you wish to add. In particular, you will want to include relevant state materials in the participants' notebook such as AIDS epidemiology and health education guidelines for your state and state information resources. Citations of state statutes, regulations, experiences of local school boards, newspaper articles, or materials you develop all can be added to the program as handouts to participants. Be sure to plan how you want to treat added materials, however. As a general rule of thumb, don't hand out anything without at least referring to it and discussing it.

  It is recommended that participants be given in their notebooks the CDC Guidelines for Effective School Health Education to Prevent the Spread of AIDS, which is referred to in the workshop. (An original copy of the guidelines can be found in the pocket inside the back cover of this notebook; the guidelines may be duplicated, or additional free copies may be obtained from the National AIDS Information Clearinghouse (1-800-458-5231).

- Transparencies: This manual includes the set of 15 overhead transparencies that are keyed to specific workshop activities as noted in Section 3 (Presenting the Workshop). The transparencies are:

  1. Goal and Objectives
  2. Clinical Spectrum of HIV Infection
  3. Tri-level Approach to Education to Prevent Infection with HIV
  4. Indicators of Youth at Risk of HIV Infection
  5. Spheres of Influence on Students
  6. Criteria for an HIV Curriculum
  7. Four Individual Elements Interact to Support All Behavior
  8. Prevention Is More Than Conveying Information
  9. Prevention Intervenes With All Four Elements
  10. Comprehensive Health Education
  11. HIV Education Can Be Integrated Into ...
  12. Resources
  13. Advisory Committees -- Benefits/Drawbacks
  14. Advisory Committees -- Who Belongs?
  15. Keys to Communication.

- Participant Notebook: Each participant should receive a copy of this notebook. It contains worksheets, briefing papers, and an evaluation form necessary for meaningful participation in the workshop. Familiarize yourself with the booklet. It is referenced by page number in Section 3 (Presenting the Workshop).

  In addition, several of the exercises included in the workshop would be useful to participants as educational activities to use in their communities with board members, administrators, professional and support staff, parents, and students. To facilitate this train-the-trainer concept, the instructions for these activities are provided in camera-ready form. They can be distributed to participants in a sealed envelope in their notebooks, handed out at the end of the workshop, or mailed to participants following the workshop. A model cover letter accompanies these materials.

Physical Arrangements for the Workshop

Since a fair amount of participation and group discussion is built into this workshop, the ideal arrangement is to seat five to seven participants at round tables throughout the room. In this way, each participant can easily see and interact with others at the table and have an unobstructed view of the faculty. Choose a strategic position for faculty presentations and projection of transparencies.

This table arrangement also allows faculty to circulate during the workshop to check on progress, estimate time needed, give instructions, and offer clarifications. By circulating among participants, faculty also increase participants' interest and involvement.

The workshop was field tested with a group of 35 school board members, a group size that allows for diversity and provides optimum opportunity for active participation by participants. The workshop should function in a similar manner for groups as large as 70. If a larger group is desired, some activities may require more time to permit adequate discussion, questioning, and repetition of instructions.

Grouping of Participants

Typically, two kinds of groupings of participants are possible in a workshop.

- Stranger groups, made up of individuals who do not know one another well (for example, school board members from different school districts).

- Home groups, made up of people who are quite familiar with one another because they work together or socialize often (for example, school board members from the same district).

Stranger groups are created simply by directing participants to sit with people from other districts as they enter the room. The advantages to such groupings include:

- Sharing a variety of experiences, ideas, and perspectives;

- Developing a broader perspective about problems, issues, and solutions; and

- Avoiding tensions, problems, and differences that may be present in a home group.

In establishing stranger groups, care should be taken to allow individuals to get acquainted with one another early in the workshop. You might ask people at each table to introduce themselves and give some information about their district, their schools, or other matters.

Home groups have several advantages, too:

- They may make direct use of the workshop to develop plans or ideas they want to put to use.
- Since they already are familiar with one another, they need no time to get acquainted.
- They have established patterns of discussion and interaction.

Your use of home or stranger groups will depend on your overall objectives and on what you know about the workshop participants. In either case, you should plan to monitor the groups' progress regularly during the workshop to ensure full participation and task-related behavior.

Equipment Needed

This workshop calls for the use of an overhead projector and screen. In addition, because many medical professionals come prepared with slides that they use for medical presentations on HIV, a carousel slide projector may be required.

Check each projector in advance to ensure that it is in good operating order. It is a good idea to have a spare projector bulb close at hand in case of malfunction.

If, because of room size, you need to use a microphone, try to use a portable one that will allow faculty to move about the workshop area.

Some activities call for jotting down ideas generated by the group. A flip chart or a chalkboard may be used, but writing on blank transparencies that are projected on a large screen will allow all participants to have a clear view of the written material.

A suggested optional activity is showing a videotape. If a videotape is shown, a tape player and monitor(s) or large screen will be required. In addition, because the HIV epidemic has generated a proliferation of videotapes that may be useful for educating adults or students, you may want to set up a viewing room where participants can view (and evaluate) videotapes between sessions.

Videotapes Available for Loan from NSBA

The following videotapes may be borrowed from NSBA for preparation or use in workshops or other presentations. To arrange to borrow a videotape, please contact the AIDS/HIV Education Project staff at 703/838-6754 or 838-6756.

Videotapes may be borrowed for a two-week period. If a videotape is to be used as part of a workshop, it is recommended that workshop faculty preview it in advance. This will assure that the videotape is appropriate to the audience and the purpose of the workshop and give the faculty time to prepare to expand upon or update information presented in the visual presentation.

HOW TO USE LEADERSHIP FOR AIDS EDUCATION (National School Boards Association, 1989)
This two-hour videotape is an edited version of the five-hour train-the-trainer session provided state school boards association staff in March 1989. The activities contained in the Leadership for AIDS Education training module are demonstrated and discussed. In addition, a brief discussion of workshop evaluation is included. Users of the curriculum provided in Leadership for AIDS Education are advised to view this videotape in advance of conducting a workshop.

AIDS: WHAT DO WE TELL OUR CHILDREN?" (Walt Disney Educational Media Co.)
This 23-minute videotape is recommended as an optional substitute for Activity 6 in the Leadership for AIDS Education curriculum. It features Carol Burnett discussing AIDS education issues with Don Francis, Centers for Disease Control, and Wendy Arnold, health educator. Their discussion focuses on many of the misconceptions parents have about talking to their children and highlights to need for schools to play a role in educating young people.

AIDS: CHOOSE TO BE SAFE (Illinois State Medical Society)
This 22-minute videotape is designed to teach adolescents about HIV transmission and prevention. It features young people exploring their knowledge and attitudes about HIV and a young woman who is HIV positive shares here thoughts, feelings, and fears about her condition. The second half features doctors answering questions from teenagers; the doctors encourage teenagers to take responsibility for their own health.

This videotape could be used as an introduction to Activity 6: Achieving Goals of HIV Education. It stresses the importance of HIV education by demonstrating that young people's behavior may put them at risk of HIV infection and they need information and skills to avoid those risky behaviors.

AIDS IN SCHOOLS (MacNeil Lehrer, PBS, 1989)
This 20-minute videotape examines how a school district in Wilmette, IL, dealt with an HIV-positive student, his family, and the community in a positive and responsible manner. The program features short interviews with the child's parents, teachers, principal, friends, his classmate's parents, and a school board member. The district was able to avoid controversy by carefully planning its strategy, educating students and parents about HIV/AIDS, and keeping the student's identity confidential.

This videotape could be incorporated into a workshop on school attendance and employment policy. It is not recommended for use with the Leadership for AIDS Education curriculum, which concentrates on HIV prevention education for students.

SECTION 3: PRESENTING THE WORKSHOP

To the Faculty

This workshop is designed for presentation in a single session of six hours. Depending on the emphasis given certain activities and on the extent to which optional activities are included, the workshop can be expanded or contracted.

The workshop enables participants to become informed about HIV from a variety of perspectives: medical; personal attitudes; and educational strategies for preventing the spread of the virus. As a result of the workshop, participants will have a better understanding of why HIV education is imperative for youth, what role school boards have in the development and implementation of HIV education, what effective HIV education comprises, and strategies for overcoming barriers to effective HIV education.

In addition, participants will have greater insight into their own attitudes, without which they will be unable to provide effective leadership in their communities. Finally, participants will take home their workbooks and other materials that they can use in moving forward with HIV education in their own communities.

The workshop is designed for three faculty members:

- A school governance expert (e.g., school boards association staff, school board member, superintendent, educational administration educator) who provides the framework for the workshop with special emphasis on the role and responsibility of schools for providing HIV education, on the board policy foundation needed for developing and implementing HIV education, and on skills and strategies for overcoming barriers to HIV education.
- A health education professional with expert knowledge of HIV and curricular approaches to teaching about HIV, and with training skills for dealing with people's sensitivities related to HIV and sexuality.
- A medical professional with up-to-date, accurate knowledge about HIV who can present essential information to a lay group in an understandable manner and respond to questions effectively and with respect for diverse viewpoints.

Included in this workshop are:

- An exploration activity that gets participants in touch with their values and feelings that may be barriers to their effective leadership regarding HIV education and that sensitizes them to the diversity of opinion and feelings that likely will be found in their communities.
- A self-administered test on HIV knowledge and a presentation (with opportunity for questions) on medical information about HIV infection.
- An exploration activity that helps participants explore their personal understanding of how HIV infection affects people.
- A presentation of the goals of HIV education for youth, including discussion of the role of schools in providing that education and opportunities for collaboration of schools, family, and community.

- An activity that helps participants recognize the basic criteria for effective HIV education.

- An activity that focuses on "what works" in health education to effect voluntary behavior decisions that promote a healthy life and prevent disease, including a presentation on options for providing HIV education in school.

- A presentation on available resources for developing and implementing HIV education.

- A presentation on establishing a policy foundation for HIV education.

- An activity that helps participants identify barriers to HIV education within their communities and plan to overcome them.

- A presentation on communication skills for managing controversy and providing leadership, including an activity that encourages participants to practice effective communication skills.

Also provided are optional additional or substitute activities related to building empathy for people who have AIDS and to the school role in HIV education.

The workshop procedures follow, along with estimated times and resources needed for each activity. The appropriate faculty member for each activity also is indicated. In addition, references to pages in the participant booklet are included. Study the workshop procedures and related materials carefully before you present the workshop. You will find additional background material in Section 5 of this manual (Resources).

Workshop Procedures

Activity 1: Overview of Workshop (Leader: School Governance)

Time: 10 minutes

Materials/Equipment: Overhead Projector

Leader Focus: This activity brings participants' attention to the workshop topic. It is critical to emphasize here that the topic is HIV education for youth, not the policy/legal issues related to managing employees and students who are infected with HIV. This activity also builds an expectation for participation in workshop activities through introduction of other faculty and the roles each will play.

- Using Transparency 1, highlight the workshop objectives:
  - -- The overall goal of the workshop is to provide board members with needed information and leadership skills to assure that effective HIV education is provided in schools.
  - -- The specific objectives of the workshop are to:
    1. Help board members understand the value of HIV education for preventing the spread of HIV, dispelling fears, and nurturing compassion and support for people infected with the virus.
    2. Clarify for board members the role and responsibility of schools in providing HIV education.
    3. Provide board members with a process for developing and implementing HIV education in the schools.
    4. Enhance board members' skills for managing controversy surrounding HIV education for youth.
    5. Provide board members with access to resources for developing and implementing HIV education.
- Discuss the underlying assumption in the workshop: Because there is no vaccine or cure, education is the only tool available to prevent the further spread of HIV.
- Introduce the two other faculty members and explain their roles.

Helpful Hint: In this activity, it is important that participants understand the scope of the workshop. Some may have elected to attend because they thought it would deal with continued school attendance or employment by people who have AIDS, or with other specific topics. This is the time for participants to adjust their expectations to what is going to happen. It can be pointed out that what is taught about HIV infection and AIDS should be consistent with policy, i.e., if students are taught that there is insignificant risk of HIV infection in the school setting, it would be inconsistent to exclude people known to be infected with the virus from the school setting without a case-by-case evaluation.

Activity 2: "Where Do You Stand?" -- Values Exploration Exercise
(Leader: Health Educator)

Time: 30 minutes

Materials/Equipment: None

Leader Focus: This activity has three purposes. It gets participants in touch with values and feelings that may be barriers to their successful provision of HIV education. It is an icebreaker at the beginning of an educational session (or an energizer for participants after lunch). It provides workshop faculty with a barometer reading of the diversity of views among participants.

- Provide rationale for exercise: School board members represent the broad and diverse views of the community. Constituents' attitudes, values, fears, and levels of information may conflict with the board's; individual board members may have differing attitudes, etc. The sensitive topic of HIV infection requires us to look at our values and feelings if we expect to enlist the support of others.

- Have people stand up. (You will need a lot of open space to allow people to articulate their views through their movements. You may want to move outside or into a long hall.)

- Explain that they will be "taking a stand" physically on certain issues as they position themselves along an imaginary continuum reflecting their values and feelings. They will then be discussing their stand (as time permits). This exercise works better for adults than for adolescents, since teenagers frequently feel uncomfortable in "taking a stand" that is perceived as different from the peer norms.

- When participants are ready, read one of the first statements from the pairs below. Then ask those people who agree with the statement to stand at a designated extreme on the "line"; those who completely disagree, to stand at the opposite extreme; and those who have mixed feelings, to position themselves somewhere between the two extremes.

  Once people are positioned, ask for volunteers from each end of the continuum and the from the midpoint to briefly articulate their positions. Continue the discussion with others as time permits. Sum up the main points, emphasizing that things are not totally black or white -- that people's views are shaded and change depending on a variety of factors. Then have participants repeat this process for the second statement of the pair.

- Pursue the following pairs of statements one at a time (use your judgment on available time and participants' readiness to reveal themselves on more sensitive values):

  -- to select which and how many pairs to do;
  -- to organize post-stand discussants, e.g., within positions vs. between/among extremes and middle; and
  -- to change, add, or delete statements based on target group.

Statements:

1a "If people continue an activity that is a health risk to themselves or to others, it is fine for the government to create laws that prohibit that personal activity."

1b "Cigarette smoking -- a known health risk -- should be more tightly proscribed to safeguard the health of nonsmokers."

2a "I believe that people who have AIDS have the right to work as long as they are able to."

2b "I would feel comfortable sharing an office with a person who has AIDS."

3a "I believe that HIV education should be taught in the schools."

3b "I would feel comfortable if my child attended school with a classmate who has AIDS."

4a "Students should be provided with AIDS education in school."

4b "I would feel comfortable teaching someone how to use a condom properly."

5a "IV drug abusers who do not share their drug paraphernalia should be allowed to continue."

5b "I would feel comfortable distributing bleach and giving directions for cleaning IV drug paraphernalia to IV drug abusers."

6a "Consenting adults should be allowed to engage in any sexual activity, so long as they do it in private."

6b "I would feel comfortable addressing the risks of HIV infection with students who may be gay."

Helpful Hint: This exercise opens people's minds to receiving information they may not know, may be uncertain about, or about which they have misinformation or misperceptions. Three to four minutes are needed for movement and discussion related to each statement. Have participants return to their seats with five minutes to spare. Have them identify any new learnings or "ah-hah" experiences. Use their feedback to bridge to the presentation on medical information about HIV infection.

Activity 3: HIV Pretest (Leader: Medical Professional)

Time: 3 minutes

Leader Focus: This activity gives participants an opportunity to assess what they know about the medical and epidemiological facts about AIDS. It opens their minds to receiving information they may not know, may be uncertain about, or about which they have misinformation.

- Ask participants to turn to page 2 in their workbooks and to spend the next three minutes answering the questions. This should be an individual exercise, not a group effort. Assure them that no one will collect their tests; they will not be graded. The pretest is to help them assess their basic knowledge about AIDS and HIV infection.

Helpful Hint: Have participants save their questions until after the medical briefing; many questions will be answered during the presentation.

Activity 4: Medical Presentation (Leader: Medical Professional)

Time: 57 minutes

Materials/Equipment: Slide Projector and/or Overhead Projector

Leader Focus: This briefing emphasizes the need to rely on accurate medical information that is based on documented evidence. It provides information relevant to what is known about HIV from the medical and epidemiological evidence, and gives special attention to the impact of HIV in the state, region, or community. The medical presentation should respond to people's concerns about, or perceptions of, "changing" medical information.

- Tell participants that you will spend approximately 30 minutes presenting information about HIV and that there will be approximately 25 minutes for questions. Advise them to jot down their questions as you talk, and to ask them following the presentation.

- Present medical and epidemiological information about HIV infection, including current data regarding AIDS cases and HIV infection in the state (region/community). Include:

  -- reference to the iceberg model (Transparency 2), which indicates that many more people are infected with HIV and asymptomatic than are clinically diagnosed with AIDS

  -- the ages of people currently reported to have AIDS, which indicate that risk of HIV infection rises throughout the teen years even though the onset of symptoms may not occur until the infected persons are in their twenties.

- Emphasize that new information about HIV infection is constantly being revealed by researchers, but that new information is not changing what is known about how HIV is transmitted. Instead, knowledge of how it is and is not transmitted is supported by a growing body of evidence. Refer participants to **page 4** in their notebooks for guidance on verifying and evaluating new information.

- Ask for questions and respond fully.

- Review the pretest by providing correct answers; that is, tell participants that all the statements are true. Discuss how people get misinformation because all sources are not reliable.

- Refer participants to **page 5** in their notebooks, where they will find information on how data on AIDS is collected and disseminated. Identify where surveillance data are collected and available in the state (recent state surveillance data should be included in participants' notebooks or available at a resource table).

Helpful Hint: Avoid use of technical terms. Remember that participants are lay members of the community with varying educational backgrounds. Explaining the nature of retrovirology, for example, is not as important as emphasizing what is known about transmission. Also, to demonstrate to people the long-term severity of the HIV epidemic, you may want to develop a state or regional map showing the spread of AIDS over several years or a graph showing current and projected cases for the community, region, or state. Visual images frequently convey a stronger message than do words and numbers. Your state or local health department may already have developed such tools or be able to assist you in developing them.

Activity 5: Transitional State (Leader: Health Educator)

Time: 25 minutes

Materials/Equipment: Overhead Projector/Blank Transparencies

Leader Focus: Assessing the array of feelings that will personalize AIDS is key here. Helping to identify and acknowledge feelings so participants will value the importance of HIV education is the primary goal of this activity. This "loss" exercise will help participants empathize with these feelings and lessen the distance they may be putting between themselves and the actuality of HIV infection.

- Ask participants to turn to **page 6** in their notebooks and to follow the directions for listing:

  1. A material possession that you value dearly;
  2. A personal or physical attribute of which you are proud;
  3. A favorite physical activity;
  4. A personal secret that you share with few people or with no one. (Have them draw a circle around the secret to signal it is "hidden.")
  5. A friend or loved one whose support has been critical to you.

Explain that this is an individual exercise and that no one will look at their answers.

- Ask participants to consider each of the following developments. With the exception of item 4, ask them to "x-out" the item as you move through each.

  1. An unforeseen financial reversal causes you to lose or sell the material possession.
  2. An accident causes the physical attribute to be lost or severely marred.
  3. An accident renders it impossible for you to engage in your favorite activity.
  4. Through a combination of circumstances, your secret is "out." (Have them erase the circle "hiding" the secret.)
  5. Because a friend or loved one has discovered your secret, your important support person abandons you.

- Ask participants how they feel about these losses. List their responses on a blank transparency. Be sure all the following are covered as reactions of persons in transition:

  -- self-devaluation
  -- anger, rage
  -- fear
  -- depression
  -- loss of control
  -- withdrawal, escapism.

- Ask participants if they recognize the connection between their feelings and the reactions of HIV-infected people.

  --Note that, during transition, infected persons may also experience social rejection (real or imagined) and mental deterioration (possibly dementia).

Helpful Hint: Before moving on, restore each of the lost items to participants. Whether through an "accident of fate" or a "case of mistaken identity," they have regained everything. Allow a moment for relief taking. Emphasize that HIV-infected people cannot have their health "restored."

Note: This exercise, and the options that follow, would be particularly useful as part of teacher inservice, as well as for employee and community education programs and in a workshop dealing with policy issues related to HIV-infected people.

Optional Substitute for Activity 5: Who Has AIDS? (Leader: Health Educator)

Time: 10 minutes

Materials: Envelopes equal to the number of participants; envelopes should be prepared before the session by writing under each flap the letter A, B, or C; approximately 10 percent should be marked with an "A"; the remainder should be divided among "B" and "C" markings.

Leader Focus: This activity will make people aware that everyone who practices risky behaviors is at risk of HIV infection. Participants will have an opportunity to realize that personal decisionmaking is linked to HIV prevention.

- Distribute one envelope to each participant.

- Ask participants to look under the flap of their envelope and remember the letter they see marked; they should not reveal the letter to anyone.

- Ask participants to stand up, walk over to someone, and exchange envelopes. Have them write their first letter next to the letter marked inside the second envelope.

- Have participants exchange envelopes again and write their first two letters next to the two marked inside the third envelope.

- Tell participants: "Those of you who have seen an "A" have been exposed to HIV, the AIDS virus. Those of you who have seen only "B's" and "C's" are still safe. Now, how many of you want to exchange envelopes one more time?" There likely will be some nervous giggling and discomfort.

- By asking the following questions, elicit participants' feelings about continuing the envelope exchange.

  - "What is preventing you from wanting to exchange envelopes again?"

  - "Is there some way in which you could exchange envelopes again but reduce your risk?" (Some people may suggest sealing the envelope, comparable to using a condom or cleaning a needle. If participants suggest erasing the "A," emphasize that HIV cannot be "erased" once a person is infected.)

- Emphasize that you don't have to get infected with HIV by chance; you can reduce your risk if you know how.

Helpful Hint: Participants could exchange envelopes with people at their table, but having them stand up and walk over to someone else provides a useful opportunity to stand up and stretch.

Optional Substitute or Additional Activity 5: **People Have AIDS**
(Leader: School Governance
and Invited Presenter)

Time: 30 minutes

Materials/Equipment: Depends on Presenter

Leader Focus: This presentation gives participants an opportunity to learn about AIDS and its effects on people directly from a person who has AIDS and/or a staff member from an AIDS service agency. It builds empathy for people who have AIDS and develops an understanding that it is not who you are but what you do that counts.

- Ask participants if any of them know a person who has AIDS or someone who knows a person who has AIDS. Whether or not hands are raised, tell participants that if the spread of HIV is not stopped, it will not be long before everyone in this room will know someone who has AIDS or someone who knows a person who has AIDS.
- Tell participants that they have a special opportunity today. For the next 30 minutes they will be facing the reality of AIDS: how it affects people physically, psychologically, socially, and economically.
- Introduce the guest. The guest should use about 15 minutes to talk about how HIV infection and AIDS affect people (himself and/or people he or she works with) and encourage questions for the remaining 15 minutes. The guest should emphasize the importance of education to prevent HIV infection as well as the need that people who have AIDS have for support from friends, family, and community volunteers.
- Thank the guest for his or her time. Sum up what participants may be feeling (sadness, empathy, desire to prevent the spread of AIDS, desire to help people with AIDS, fear of becoming infected with HIV, etc.).

Helpful Hint: Personalizing AIDS through this presentation may make people uncomfortable. People who have AIDS and AIDS service providers can help you assess whether your audience is ready for this kind of presentation. Service providers also can put you in touch with persons who have AIDS who are comfortable about making public presentations and sensitive to participants' concerns and attitudes. You should meet with such persons before making a final decision to discuss the content and structure of the presentation. It is not wise to use speakers with whom you have not previously discussed your aims for this workshop. Local community-based service providers may be able to provide assistance in developing this presentation, or you can contact the National Association of People With AIDS (NAPWA), 2025 I St., N.W., Suite 415, Washington, DC 20006 (202/429-2856).

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15 MINUTE BREAK

(A break at this time, approximately two hours into the workshop, gives people a chance to collect their thoughts about what they have experienced before they begin activities directly related to HIV education in schools.)

Activity 6: Achieving Goals of HIV Education (Leader: Health Educator or School Governance)

Time: 30 minutes

Materials/Equipment: Overhead Projector/Blank Transparency

Leader Focus: This activity will develop a working knowledge of the goals of HIV education (based on guidelines published by the Centers for Disease Control) and of the steps for achieving them. It will lead participants to an understanding of the benefits of community collaboration for preventing the spread of HIV.

- Using **Transparency 3**, discuss the primary goal of HIV education: To prevent the spread of HIV by giving youth the knowledge and skills they need to adopt and maintain behaviors that virtually eliminate their risk of infection.

  -- Review the tri-level approach to HIV education, which is contained in the CDC Guidelines for Effective School Health Education to Prevent the Spread of AIDS (participants should receive copies of the Guidelines).

  Elicit from participants their understanding of the rationale for this tri-level approach. Emphasize that if HIV is present, changing or avoiding risky behaviors is the only way to stop its spread.

- Ask participants what barriers to the tri-level approach to HIV education might be found in their communities. Write their responses on a blank transparency (or chalkboard or flip chart). Include:
  -- denial of problem (of AIDS, of sexually active or drug-abusing teens).

- Using **Transparency 4**, tell participants that it is not always possible to know who is sexually active or who abuses drugs, but evidence to support the need for the tri-level approach in a community can be found through the following sources:

  -- Data for sexually transmitted disease (STD), pregnancy, abortion, and birth rates among teens;
  -- Records for drug-related arrests, treatments, and school disciplinary actions;
  -- Anecdotal or survey information from medical, religious, and social service providers, and from teachers, guidance counselors, parents, and students.

  Local sources for this information might be the school district, health department, medical association, social service agencies, Planned Parenthood, youth club sponsors, clergy, etc.

- Using **Transparency 5**, discuss the spheres of influence on students (family, school, community) and the program components of each that support HIV instruction for youth. Discuss the value of collaborating with others in the community to identify the roles of each in preventing the spread of HIV.

- Ask participants to turn to **page 10** in their notebooks and work in small groups to identify "who" has the primary responsibility for the stated tasks and "what" the school role should be. Divide tasks among tables so that all will be addressed (e.g., two tasks per table).

- Ask for responses to each task. Discuss differences of opinion.

- Display **Transparency 5** again and sum up that the responses demonstrate the need for collaboration.

- Have participants turn to **page 11** in their notebooks and advise them to use the outline provided, when they return home, to identify agencies and organizations in their own communities that should be involved with schools in addressing comprehensive HIV education.

Helpful Hint: Agree that different communities will respond in different ways. There are no wrong answers unless no one is willing to take responsibility for one or more tasks.

Optional Substitute for Activity 6: **AIDS: What Do We Tell Our Children?**
(Leader: Health Educator or School Governance)

Time: 35 minutes

Materials/Equipment: VCR and TV monitor(s)
Videotape: "AIDS: What Do We Tell Our Children?"

Leader Focus: This activity is directed at clarifying for participants the responsibility schools have for collaborating with family and community to educate students about HIV.

- Introduce the videotape and ask participants to consider the role of schools and of others as they watch the film.

- Following the videotape, ask participants for their comments on the role of schools in preventing the spread of HIV.

- Display **Transparency 5** and sum up the responses that demonstrate the need for collaboration and the specific roles schools can play.

Helpful Hint: Agree that different people/communities will respond in different ways. There are no wrong answers unless no one is willing to take responsibility for a task.

Note: The recommended video, which features Carol Burnett discussing HIV education with a health educator and a CDC physician, emphasizes the collaborative role of school and family. It may be most suitable for white, middle-class audiences, however. It runs 22 minutes and costs $345 per copy (VHS only). Order from: Walt Disney Educational Media Company, c/o Coronet/MTI Film & Video, 108 Wilmot Rd., Deerfield, IL 60015 (800/621-2131; 312/940-1260).

Preview a copy of the film before deciding to purchase it; find out if your state or local health department or state education department has a copy available for loan, or encourage the health department or a local university to purchase a copy for loan purposes. NSBA has purchased a copy of this videotape for loan to state school boards associations to use in their workshops; arrangements can be made through the NSBA AIDS Education Manager.

Activity 7: Criteria for Effective HIV Education (Leader: Health Educator)

Time: 25 minutes

Materials/Equipment: Overhead Projector

Leader Focus: In this activity, participants will identify the criteria for an effective HIV education program for students from the perspectives of information provided, instructional methods, instructional materials, and personnel.

- Ask participants to turn to **page 12** in their notebooks and complete the exercise. This can be either an individual or small-group exercise, depending on the overall size of the group.

- Ask for volunteers to respond to each statement and provide an explanation for the answer. If the response is incorrect, ask for a volunteer to explain the correct response.

Statements -- Responses in ( )

1. HIV instruction should be geared to the chronological and developmental age of children.

   (Y) Decisions regarding the appropriateness of material to specific grade levels should be influenced by the advice of educators regarding the readiness of children to understand and learn concepts. There are no rules, however; the readiness of children for specific information and skills may vary depending upon the conditions, needs, and values of a specific community.

2. The content of the curriculum should be based on information from reliable medical sources and delivered in specific terms that children understand.

   (Y) To clarify the need for using language that students understand, tell about the student who responded that "casual contact" means "one-night stands," which translates to no risk from one-night stands.

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3. To effectively teach children about AIDS and HIV infection, a teacher needs nothing but accurate information on the subject.

   (N) A teacher's attitudes, knowledge, comfort with the material, and teaching ability are important factors. How teachers are selected and trained is critical.

4. HIV education may be most effective when integrated into a comprehensive K-12 health education program that focuses on promoting good health, self-esteem, and decision-making and negotiating skills.

   (Y) Promoting good health habits and the skills for making personal decisions from an early age gives children a foundation of good health behaviors and the practical skills for using new information appropriately.

5. The best time to teach children the specific ways to avoid infection with HIV is before they become sexually active or begin using illicit drugs.

   (Y) Children need to be able to protect themselves from infection before they are faced with decisions about such behaviors: One mistake may be fatal.

6. Parents should have an opportunity to review the curriculum and instructional materials before their children receive instruction about HIV.

   (Y) For two primary reasons: to reduce controversy and to enable parents to reinforce what is learned in school through discussion at home.

7. The curriculum should focus on the biological aspects of the disease.

   (N) Teaching healthy behaviors and the skills for practicing them is more important than learning technical details about the immune system and viruses.

8. The curriculum should include information for students on where to obtain additional information.

   (Y) Providing information about such resources as AIDS hotlines, testing sites, and support groups enables students to follow up according to their personal needs or interests.

9. The most important fact students should learn about HIV infection is that it can be prevented by avoiding risky behaviors -- it is not who you are, but what you do that counts.

   (Y) The goal should be to reduce both fear and denial of vulnerability by giving students the information and skills they need to reduce their risk.

10. Only certified health education teachers need training to teach about HIV.

    (N) All teachers should receive training to be able to respond to students' questions correctly and to integrate information about HIV into other subjects appropriately. Moreover, all school employees should be educated about HIV to assure that information throughout the school community is consistent; all school employees should be able to and be encouraged to interject correct information when AIDS "myths" are overheard, e.g., "I never use the school bathrooms. I'm afraid of catching AIDS."

- Display Transparency 6, Criteria for an HIV Curriculum. Summarize the primary criteria.
- Refer participants to **pages 14-16** in their notebooks for additional guidance on considerations and criteria for HIV education.

LUNCH BREAK

(This is the most appropriate time to break for lunch; the alternative is following Activity 9, approximately 30 minutes later.)

Activity 8: Does Education Work to Promote Healthy Behaviors?
(Leader: Health Educator)

Time: 25 minutes

Materials/Equipment: Overhead Projector

Leader Focus: This activity makes participants aware of the difference between providing information and actually influencing behavior.

- Ask participants to stand up. Tell them, "We are going to play 'lifestyles fastball.' I am going to make some statements. If a statement is not true for you, please sit down."

  -- In the last month, I have always worn my seatbelt while driving.

  -- I haven't smoked any cigarettes in the last year.

  -- I eat a balanced breakfast every day.

  -- I have not had alcohol before driving my car in the last month.

  -- I exercise three times a week every week.

  -- I get seven hours of sleep every night.

  -- I floss my teeth every day.

  Most people will be seated at the end of this exercise--and laughing.

- Acknowledge what they have just realized: It takes more than information to affect people's behaviors. Explain that the challenge is even greater for young people because they believe they are immortal and invulnerable, they may base decisions on misinformation, they have a propensity for risk taking, and they are subject to peer pressure. When it comes to HIV infection, they say:

  -- "It won't happen to me."
  -- "We're in love and will be together forever." Definition of "forever" is three months.
  -- "Girls who carry condoms are sluts." "Boys who carry condoms are suckers."
  -- "I trust my friends."

  It requires a jump of faith to believe that merely dispersing information about HIV will lead to reduced risk for adolescents. Showing a film or spending one class session providing information is unlikely to influence behavior. Education that results in voluntary behavior change needs to empower people to make good decisions based on correct knowledge and supported by usable skills.

- Using Transparencies 7, 8, and 9, explain how four elements interact to support all behaviors: knowledge, attitudes, skills, changes in behavior. Prevention techniques must intervene with knowledge, attitudes, and skills to lead to planning and negotiating risk reduction behaviors. Refer participants to page 20 in their notebooks for information on the effectiveness of health education in promoting healthy behaviors.

- Review the components of comprehensive health education (Transparency 10): A planned sequential kindergarten-12 curriculum that addresses the physical, mental, emotional, and social dimensions of health and provides opportunities for students to develop and demonstrate health-related knowledge, attitudes, skills, and practices.

  The ten content areas are:

  -- Community health
  -- Consumer health
  -- Environmental health
  -- Family life and human sexuality
  -- Growth and development
  -- Nutritional health
  -- Personal health
  -- Prevention and control of disease and disorders
  -- Safety and accident prevention
  -- Substance use and abuse.

  Instruction about HIV can be presented in the context of this total health curriculum designed to affect students' knowledge, attitudes, skills, and practices. By starting in the early grades, an emphasis on helping children to be healthy and building self-esteem and decisionmaking skills can be firmly grounded before specific information on sexual practices is presented.

- Explain that HIV instruction need not be limited to the health education curriculum. Use **Transparency 11** to highlight how other subject areas offer opportunities for integrating instruction about HIV. Ask participants if there are other ways in which the subject of prevention of HIV infection can be incorporated (e.g., reading, writing, critical thinking skills, math).

Helpful Hint: This activity provides an appropriate opportunity to examine state education department guidelines for health, family life, and HIV education. If you plan to discuss state guidelines, be sure to include them (or a summary) in the participant notebook.

Activity 9: **Resources for Getting Started and Beyond**
(Leader: Health Educator or School Governance)

Time: 10 minutes

Materials/Equipment: Overhead Projector

Leader Focus: Presentation of the following material, which is either included or referenced in the participant notebook, will give participants important resources that should be consulted as an HIV education program is developed in their district. Incorporate into the presentation the value of adapting available resources to local needs or using them as a foundation for curriculum development to avoid unnecessary duplication of effort.

- Display **Transparency 12** and review resources that are helpful in developing and implementing HIV education. Ask for input from participants regarding additional resources they may know about.

  General Information

  -- AIDS Hotlines (local, state, and national)

  -- National AIDS Information Clearinghouse (NAIC)

  -- National and Community-Based Organizations

  Guidelines

  -- State Health Education Curriculum Objectives and Guidelines

  -- State Family Life Education Curriculum Objectives and Guidelines

  -- Centers for Disease Control (CDC) Guidelines for Effective School Health Education to Prevent the Spread of AIDS

  -- U.S. Department of Education's AIDS and the Education of our Children

  -- Criteria for Evaluating an AIDS Curriculum (National Coalition of Advocates for Students)

Curricula and Audio/Visual Materials

-- Commercially Published Curricula

-- Commercially Produced Audio-Visual Materials

-- Curricula and Materials Developed by Local Districts and State Education Agencies

-- CHID (Combined Health Information Database) AIDS School Health Subfile (computer accessible)

Medical and Technical Information

-- Issues of the Morbidity and Mortality Weekly Report Supplement (MMWR), Centers for Disease Control, that report on HIV

-- Centers for Disease Control (CDC) and State Health Department AIDS Surveillance Reports

-- Public Health Agencies

Educational Research

-- Education that Influences Behavior

Personnel

-- School Personnel (teachers, school nurses)

-- Nonprofit Organizations (American Red Cross, American Medical Student Association, Planned Parenthood, AIDS support and service organizations)

-- Advisory Committees, School Health Councils

-- Local Public Health Agencies

Policy

-- Policy Services, Publications, and Workshops from State School Boards Associations and NSBA

- Refer participants to pages 38-41 in their notebooks, where useful resources are listed.

Activity 10: Establishing a Policy Foundation (Leader: School Governance)

Time: 20 minutes

Materials/Equipment: Overhead Projector

Leader Focus: This activity is designed to demonstrate to participants that a variety of school board policies provides a framework for guiding and supporting an effective process of developing and implementing HIV education.

- Refer participants to **page 24** in their notebooks, to present a brief overview of the value of written board policies. Point out how written policies that a board should already have in place provide a framework for dealing with HIV education:

  -- for hearing diverse viewpoints and building consensus (policies on involvement of community, staff, and students in decisionmaking)

  -- for managing controversy (policies on public information, media relations, complaints)

  -- for assuring that curriculum and teachers are appropriately prepared (policies on curriculum development, staff development).

  Emphasize the role of policy in building broad-based support for HIV education and minimizing controversy through involvement in decisionmaking, public information program, and public confidence in a school district's ability to provide a sound instructional program.

- Refer participants to **page 25** in their notebooks and discuss the need for a specific policy on HIV education.

  Participants should ask themselves: "Is it important in my community for the board to state in writing what it believes the schools should do about HIV education?"

  Explain how some districts are incorporating policy on HIV education into policies dealing with HIV-infected staff and students; others are adopting specific HIV education policies.

Helpful Hint: Additional activities on the value of written policy and the policy development process can be added here if necessary. Or, participants can be encouraged to attend other workshops that focus on policy.

Activity 11: Overcoming Barriers to HIV Education (Leader: School Governance)

Time: 30 minutes

Materials/Equipment: Overhead Projector/Blank Transparency

Leader Focus: This activity gets participants to identify barriers to implementing HIV education in their communities and think through ways to overcome them. Participants should complete this activity with the knowledge that barriers are not insurmountable, but can be managed if anticipated.

- Ask participants what they foresee as barriers to implementing HIV education in their schools. Using a blank transparency (or chalkboard or flip chart), write down participant comments. Be sure to cover:

  --Community values and attitudes
  --Special interest groups
  --Objections to sex education
  --Changing information about HIV
  --Apathy toward the HIV epidemic
  --Ill-equipped teachers
  --Lack of curriculum
  --Inertia of, or avoidance by, board/district due to fear of controversy.

- Ask participants to turn to page 26 in their notebooks. Assign one or two barriers to each table and have participants work together as a group to identify appropriate means for overcoming each barrier assigned. Advise them to think about how policies set the stage for overcoming barriers (e.g, policies that enable people to voice their opinions).

- Table by table, ask volunteers to share their group's solutions with everyone. Guide the discussion to elicit the following ways to overcome the respective barriers.

  -- Community values/attitudes: Provide opportunities for involvement through broad-based community advisory committees, education programs for parents and community, public hearings on curriculum adoption; allow parents to review instructional materials.

  -- Special interest groups: Build support among majority of community; identify areas of agreement; involve special interest groups in planning; provide opportunities for all to be listened to; be willing to acknowledge that a different approach may be better--sometimes the most vocal people are right.

  -- Objections to sex education: Find out what is objected to; provide procedures for parents to have their children excused from some classroom instruction; educate community regarding how sex education is part of comprehensive health education; build on support of majority of community.

  -- Changing information about HIV: Build in a process for periodic review of curriculum to incorporate new information based on authoritative medical evidence; determine criteria for evaluating information; show that scientific conclusions about how HIV is transmitted have remained stable.

-- Apathy toward HIV epidemic: Work with health authorities to provide relevant community education by assembling local and state data on AIDS and for STD, pregnancy, abortion, and illicit drug use among teens; enlist media support.

-- Ill-equipped teachers: Develop plan for staff selection and development/inservice; address teacher attitudes and values during inservice; involve staff in curriculum development; provide HIV education for all school employees; identify supplemental or alternative community resources.

-- Lack of curriculum: Identify existing resources; consult with other districts; develop local curriculum.

-- Inertia toward, or avoidance of, topic by board: Educate board members about HIV and the importance of HIV education; adopt policies that enable managing controversy; prepare board members to deal with controversy.

- Ask participants how many have used community advisory committees to assist in developing policy or programs. Using Transparency 13, review the benefits and drawbacks of community advisory committees.

Benefits

-- Potential critics involved in planning
-- Diverse and fresh viewpoints elicited
-- Consensus on goals and objectives possible
-- Builds broad-based support for recommendation
-- Can provide board with new information

Drawbacks

-- May slow process
-- Consensus recommendation may be inadequate
-- Burden on staff to provide support

Have participants turn to page 28 in their notebooks and, individually, complete the exercise on HIV Education Advisory Committees.

Review the exercise by asking if the following categories of people were included (use Transparency 14):
-- parents
-- students
-- teachers
-- principals
-- curriculum specialists
-- research and evaluation specialists
-- medical experts
-- clergy
-- representatives of key civic organizations
-- other?________________________(e.g., persons who have AIDS, AIDS service and support organizations, AIDS educators from public or nonprofit organizations)

Helpful Hint: If state curriculum guidelines for health, family life, or HIV education include a model for community involvement, include it in the participant notebook and refer to it in the presentation.

---

15 MINUTE BREAK

(This is an appropriate time to schedule an afternoon break. To maintain the flow of activities, you may not want to schedule an actual break, but encourage participants to get refreshments, etc., as desired.)

Activity 12: Communication Skills (Leader: School Governance)

Time: 45 minutes

Materials/Equipment: Overhead Projector

Leader Focus: School boards that take a leadership role in providing HIV education to students place board members in the front lines of controversy. This activity gives participants an opportunity to practice what they have learned about HIV infection and how HIV education might be provided by testing themselves on how they would respond ("think on their feet") when confronted with various difficult situations concerning HIV education.

- Discuss with participants how their communication skills can either manage controversy or fan the flames of discontent. Board members must be skillful in making public presentations; gaining support for HIV education may require board members to get out in the community to explain policies and what students will learn (and why). Board members also need to be skilled in responding to questions and in dealing with confrontation.

- Using **Transparency 15**, present an overview on communication skills:

  -- Your personal communication has a strong impact on people's attitudes. You can escalate or diffuse a difficult situation by what you say.

  -- "Paraphrasing" helps you make sure you understand the other person.

  -- Listen to others' feelings to help them deal with their problems logically. Anchor your response in logic and accurate information; explain your views based on a rationale.

  -- Be "assertive" in explaining how you see a situation and how you feel about it, but be knowledgeable about a subject before you speak about it.

  -- Think of several possible responses to questions or comments, evaluate the consequences of each, and select one.

- Refer participants to **pages 31-32** in their notebooks. Assign one situation to each table and have the table teams develop a series of possible responses for each situation. (4-6 minutes)

- Ask for volunteers from each table to role-play their assigned situation. Say that there is no "right" answer, but some responses may be more successful than others.

- Following each scenario, solicit comments on:
    - -- How could the respondent have been more effective?
    - -- Were there alternative ways to respond?
- Refer participants to **pages 33-36** in their notebooks, which contain some suggested responses they may find useful in the future.

Helpful Hint: Forty-five minutes clearly is insufficient time to teach people how to be skillful communicators. This exercise is intended to give participants a brief introduction to communication skills. They should be advised that most state school boards associations offer or can provide seminars on communication skills and public relations.

Activity 13: Summing Up (Leader: School Governance)

Time: 15 minutes

Materials/Equipment: Overhead Projector

Leader Focus: This activity reviews what participants have learned, gives them direction for using what they have learned, and is a transition to evaluation of the workshop by participants.

- Display **Transparency 1** and review the objectives set forth for the workshop. Review how each objective was covered.
- Charge participants with developing a plan for what they will do back home with what they learned during the workshop. Refer them to **page 37** in their notebooks, which is a checklist for starting and monitoring HIV education activities.
- Encourage coordination with state education and state and local health departments for technical assistance, resources, and training. Refer participants to the list of HIV Education Resources in their notebooks, **pages 38-41**.
- Ask participants to complete the workshop evaluation form. Thank them for their active involvement and good ideas.

SECTION 4: EVALUATING THE WORKSHOP

Evaluation of processes and materials has been a built-in feature of this workshop during its development and testing phase. Initial testing, carried out by the National School Boards Association, focused on:

- Relevance and clarity of objectives;
- Relevance, clarity, and adequacy of treatment of subjects covered;
- Usefulness of participant notebook;
- Clarity and usefulness of audio-visual materials;
- Receptivity of participants to presentation styles, activities, and materials; and
- Time allocations for various portions of the workshop.

The workshop fieldtest received an overall rating of 3.69 on a 4.0 scale.

As a workshop leader, you are encouraged to continue evaluating the workshop to find ways to improve or modify it for your purposes.

Why Evaluate?

Continuous participant feedback as you present the workshop can be helpful in several ways:

- Personal growth and development. Whether you are new to workshop presentations or a seasoned veteran, participant feedback can be helpful in your personal and professional development. Participant evaluation of your presentation style, of how helpful you were in their learning, and of how you handle time and materials can be invaluable to you as a source of growth.
- Adapting the workshop. Participant feedback can give you ideas and suggestions that will help you plan future presentations of the workshop. Perhaps more time needs to be spent in one area. Perhaps objectives need to be made clearer. Perhaps participants grew too tired during a two-hour stretch. These participant perceptions and feelings will provide information to consider as you continuously adapt and modify the workshop in successive presentations.
- Improving materials and activities. Participant feedback will give you clues as to how to improve the basic workshop structure and materials. Perhaps you will need to add more specific legal or statutory information about your state. Perhaps you will need to provide a description of your state's HIV education guidelines, or of additional resources available in your state.

What to Evaluate

An adequate evaluation of a workshop provides the information you need to determine how well the presentation achieved your objectives. It also gives you an indication of how well the presention met the needs and expectations of participants.

- Objectives. The objectives of the workshop are stated in terms of knowledge/information that participants are expected to gain, skills they are expected to develop, or attitudes they are expected to have as a result of the experience.

  Evaluation of objectives can involve questions of clarity (Are the objectives clear to participants?), questions of appropriateness or match (Do the objectives meet participants' needs and expectations?), and questions of achievement (Do participants gain in information, skills, and attitudes?).

  The first two kinds of questions are relatively easy to assess during the workshop. The third, although very important, is the most difficult to assess.

- Presenter(s). The skills of the presenter(s) in conducting the workshop is another area for evaluation.

  Questions in this area might focus on the presenter's delivery of lectures, helpfulness in workshop activities, knowledge of the subject, and other skills or expertise.

- Workshop processes. These include the procedures and activities designed to result in learning. Among the workshop processes are presentations, small and large group discussions, and group and individual activities.

  Evaluation of these processes involves questions regarding their contribution to participants' understanding, learning, and skill development.

Questions for Evaluating the Workshop

The evaluation form that follows is included in the camera-ready participant booklet. The form includes a comprehensive and adequate set of workshop evaluation questions; the questions speak to objectives, presenters, and processes.

HIV EDUCATION WORKSHOP EVALUATION

Please answer the following questions. Your candid and thorough responses will assist the association in planning future presentations.

I am ____ a board member ____ a superintendent ____ other __________ (specify)

1. Please rate each of the following components of this workshop by circling the appropriate number (write any comments in the appropriate spaces):

	Excellent	Good	Fair	Poor
Workshop Objectives				
Clarity	4	3	2	1
Relevance to your needs	4	3	2	1
Achievement in workshop	4	3	2	1

Comments ____

____

	Excellent	Good	Fair	Poor
Subjects Covered				
Medical Information				
Relevance to workshop	4	3	2	1
Clarity of presentation	4	3	2	1
Activities	4	3	2	1
Attitudes Toward HIV				
Relevance to workshop	4	3	2	1
Clarity of presentation	4	3	2	1
Activities	4	3	2	1
School Board Role				
Relevance to workshop	4	3	2	1
Clarity of presenation	4	3	2	1
Activities	4	3	2	1
HIV Instruction				
Relevance to workshop	4	3	2	1
Clarity of presentation	4	3	2	1
Activities	4	3	2	1
Policy Foundation				
Relevance to workshop	4	3	2	1
Clarity of presentation	4	3	2	1
Barriers to HIV Education				
Relevance to workshop	4	3	2	1
Clarity of presentation	4	3	2	1
Activities	4	3	2	1

	Excellent	Good	Fair	Poor
Communication Skills				
Relevance to workshop	4	3	2	1
Clarity of presentation	4	3	2	1
Activities	4	3	2	1

Comments____

____

Participant Notebook				
Usefulness to you in workshop	4	3	2	1
Anticipated future usefulness	4	3	2	1
Organization	4	3	2	1

Comments____

____

Audio-Visual Materials				
Usefulness to presentation	4	3	2	1
Organization	4	3	2	1
Clarity/visibility	4	3	2	1

Comments____

____

Presenters				
________________(School Governance)				
Knowledge of topic	4	3	2	1
Organization	4	3	2	1
Presentation skills	4	3	2	1
________________(Health Educator)				
Knowledge of topic	4	3	2	1
Organization	4	3	2	1
Presentation skills	4	3	2	1
________________(Medical Professional)				
Knowledge of topic	4	3	2	1
Organization	4	3	2	1
Presentation skills	4	3	2	1

Comments____

____

Overall workshop rating	4	3	2	1

Comments____

____

2. Did this workshop meet your expectations? ___Yes ___No
Why or why not?

____

____

3. Are there additional objectives this workshop should include?
(Please be specific.)

____

____

4. What I would like more of in this workshop is:

____

____

5. What I would like less of in this workshop is:

____

____

6. How will this workshop assist you in the future?

____

____

Additional Comments and Suggestions

____

____

____

____

____

Evaluating for Results

The underlying goal of this workshop is to enable school board members to provide leadership for implementing HIV education programs for youth in schools. Progress in the amount, scope, and process of HIV education in schools can be measured by the collection of baseline data (What were participants' school districts doing about HIV education before the workshop?) and results data (What are participants' school districts doing as a result of the workshop?).

Collecting Baseline Data

The questionnaire that follows is provided as a tool for collecting baseline data from workshop participants. It can be sent with the registration forms for the workshop so that participants return the form when they register, to participants upon registration with the request that it be returned prior to the workshop, or built into the workshop as a beginning activity.

The highest percentage of return will result from having participants fill out the questionnaire at the workshop. Board members may not have adequate information, however, to complete the questionnaire accurately. Completion at the workshop also will not give faculty time to tailor the workshop to the specific needs of participants.

The next best method is to send the questionnaire with the workshop announcement and registration materials. This process enables participants to seek assistance from district staff in completing the questionnaire. It also allows for early analysis of the baseline data and tailoring some portions of the workshop according to participants' needs. For example, the responses may indicate a greater or lesser need for the medical presentation, or increased emphasis on working collaboratively with other community organizations.

PREWORKSHOP QUESTIONNAIRE

Please respond to the following questions and return this questionnaire with your registration form.

1. School District Name ______________________________

2. My school district can be described as:

   rural __ urban __ suburban __.

3. Our school district currently provides HIV education to:

   ___ Students (Grades ____________________)

   ___ Instructional Staff

   ___ Support Staff

   ___ Parents

   ___ Other Community Members

4. The greatest barrier to providing students with school-based education about HIV is

   ____

   ____.

5. I need more information on:

   ___ Medical facts related to AIDS and HIV infection

   ___ School responsibility and role in providing school-based HIV education

   ___ Effective health education strategies

   ___ Other (Please describe) ______________________

   ____

6. The most pressing question I have about AIDS and HIV infection is:

   ____

   ____?

Thank you for completing this form. It will help us to be responsive to your needs during the workshop.

Please return this form with your registration form to:

Collecting Follow-up Data:

The readiness of participants to act on what they learn in this workshop will vary considerably. Some, who may be attending the workshop because they want to improve upon what they already are doing, can take steps immediately. Others may just be starting and may, therefore, have to build community support over time.

Given the range of conditions that can be anticipated, the collection of follow-up data should not occur too soon. Waiting six to nine months before sending a follow-up questionnaire should demonstrate whether any positive results have occurred.

The following model for a mailed questionnaire is designed to collect follow-up data. An alternative approach that should result in increased responses is to collect the follow-up data collection, using these or similar questions, by telephone.

POSTWORKSHOP QUESTIONNAIRE

Several months ago, you attended the association's workshop on HIV education. The underlying goal of that workshop was to help you provide leadership toward the development and implementation of HIV education in your schools.

We are interested in knowing if your participation in that workshop has helped you and your district make progress toward providing HIV education to students in your schools. Please take a few moments to complete this questionnaire. The information you provide will help us to improve the workshop for future presentations.

1. School District Name ______________________________

2. Did you report to your board about the workshop? ___ Yes ___ No

3. Has your district: (please answer both parts of each question)

Planning

a. Collected community data on the cumulative incidence of AIDS?
___ yes
___ no, but it is planned
___ no
Did the workshop influence this activity? ___ yes ___ no

b. Collected community data on the prevalence of teen risk behaviors and teens' HIV-related knowledge and attitudes?

___ yes
___ no, but it is planned
___ no
Did the workshop influence this activity? ___ yes ___ no

c. Found out about community-based HIV education efforts?

___ yes
___ no, but it is planned
___ no
Did the workshop influence this activity? ___ yes ___ no

d. Found out about state education department or state and local health department plans, requirements, and resources regarding HIV education?

___ yes
___ no, but it is planned
___ no
Did the workshop influence this activity? ___ yes ___ no

Community Involvement

e. Identified support systems and barriers in the community?

___ yes
___ no, but it is planned
___ no
Did the workshop influence this activity? ___ yes ___ no

Explain: ____

____

f. Established a process for staff, parent, and student involvement in planning, implementation, and evaluation of HIV education?

___ yes
___ no, but it is planned
___ no
Did the workshop influence this activity? ___ yes ___ no

g. Established a plan for communicating with parents about HIV education?

___ yes
___ no, but it is planned
___ no
Did the workshop influence this activity? ___ yes ___ no

h. Established an advisory committee to guide HIV education efforts?

___ yes
___ no, but it is planned
___ no
Did the workshop influence this activity? ___ yes ___ no

If an advisory committee has been established, who is included on it?

____

____

Policies

i. Adopted policies on employees and students who have AIDS or are HIV-infected? (if yes, please attach copies)

___ yes
___ no, but it is planned
___ no
Did the workshop influence this activity? ___ yes ___ no

j. Adopted a policy on HIV education? (if yes, please attach copy)

___ yes
___ no, but it is planned
___ no
Did the workshop influence this activity? ___ yes ___ no

Implementation

k. Supported curriculum development activties for HIV education?

___ yes
___ no, but it is planned
___ no
Did the workshop influence this activity? ___ yes ___ no

Explain: ____

____

l. Reviewed HIV education instructional materials available for use in schools?

___ yes
___ no, but it is planned
___ no
Did the workshop influence this activity? ___ yes ___ no

m. Supported training of HIV education teachers?

___ yes
___ no, but it is planned
___ no
Did the workshop influence this activity? ___ yes ___ no

Evaluation

n. Planned for evaluation of the HIV education program?

___ yes
___ no, but it is planned
___ no
Did the workshop influence this activity? ___ yes ___ no

o. Received periodic status reports from staff on implementation of HIV education?

___ yes
___ no, but it is planned
___ no
Did the workshop influence this activity? ___ yes ___ no

p. Received periodic status reports from staff on HIV-related knowledge, attitudes, and behaviors among teens in the community?

___ yes
___ no, but it is planned
___ no
Did the workshop influence this activity? ___ yes ___ no

q. Identified continuing or new barriers to HIV education and addressed them appropriately?

___ yes
___ no, but it is planned
___ no
Did the workshop influence this activity? ___ yes ___ no

r. Determined success of education plan in affecting students' HIV-related knowledge, attitudes, and behaviors?

___ yes
___ no, but it is planned
___ no
Did the workshop influence this activity? ___ yes ___ no

s. Revised plans as necessary?

___ yes
___ no, but it is planned
___ no
Did the workshop influence this activity? ___ yes ___ no

3. Our district currently provides HIV education to:

___ Students (Grades _____________________________)

___ Instructional Staff

___ Support Staff

___ Parents

___ Other Community Members

4. The greatest barrier to providing students with HIV education is:

____

____

5. The most pressing question I have about AIDS and HIV infection is:

____

____

Thank you for completing this questionnaire. Please return it to:

SECTION 5: RESOURCES
(Revised, August 1989)

This section contains topical background reading that the workshop faculty should become familiar with prior to conducting the workshop on HIV education. You may want to reproduce some of these materials (or obtain original copies) to include in workshop notebooks.

Materials in this section are (bold type indicates August 1989 addition):

- **HIV/AIDS Surveillance Report (Centers for Disease Control, August 1989)**
- The Facts--Adolescents, AIDS and the Human Immunodeficiency Virus (Center for Population Options, 1988)
- **"First 100,000 Cases of Acquired Immunodeficiency Syndrome -- United States," (Morbidity and Mortality Weekly Report, August 18, 1989)**
- **"Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health-Care and Public Safety Workers" (Morbidity and Mortality Weekly Report, June 23, 1989)**
- **"HIV Epidemic and AIDS: Trends in Knowledge -- United States, 1987 and 1988" (Morbidity and Mortality Weekly Report, May 26, 1989)**
- Criteria for Evaluating an AIDS Curriculum (National Coalition of Advocates for Students, NCAS, 1988)
- **Adolescents, AIDS and HIV: Guidelines for Review (Center for Population Options, April 1989)**
- "Certain Practices of School-Age Youth," excerpt from How Effective is AIDS Education? (Office of Technology Assessment, U.S. Congress, 1988)
- Dealing with Controversy: The School Board's Perspective (NSBA presentation, 1988)
- Churches Call for Education on AIDS (National Council of the Churches of Christ in the USA, 1987)

In addition, original copies of the following materials are provided in the pocket inside the cover of this manual:

- Surgeon General's Report on Acquired Immune Deficiency Syndrome (U.S. Department of Health and Human Services, 1986)
- Guidelines for Effective School Health Education to Prevent the Spread of AIDS (Centers for Disease Control, 1988)
- AIDS and the Education of Our Children: A Guide for Parents and Teachers (U.S. Department of Education, 1987)

- **School Systems and AIDS: Information for Teachers and School Officials** **(American Red Cross, 1989)**
- **User Guide** **(National AIDS Information Clearinghouse, 1989)**
- **NAIC Conference Calendar** **(National AIDS Information Clearinghouse, 1989)**

You may wish to provide copies of some of these materials to workshop participants. To order additional copies:

Surgeon General's Report
CDC Education Guidelines
National AIDS Information Clearinghouse (NAIC)
1-800-458-5231

AIDS and the Education of Our Children
Office of Public Affairs
U.S. Department of Education
400 Maryland Avenue, SW
Washington, DC 20202

School Systems and AIDS: Information for Teachers and School Officials
Contact your local chapter or regional operations center of the American Red Cross

HIV/AIDS Surveillance Report, Centers for Disease Control, August 1989

This report is issued monthly by the Centers for Disease Control. It provides up-to-date statistics on the AIDS epidemic.

To receive this free monthly Report, write to:

Centers for Disease Control
Division of HIV/AIDS
Technical Information Activity, Mailstop G-29
Atlanta, GA 30333.

To receive multiple copies of a Report, (for example, to include in a workshop notebook), contact the National AIDS Information Clearinghouse at 1-800-458-5231.

Most state health departments issue periodic reports containing state data. To receive these reports, contact the AIDS coordinator in your state health department (see Resources section of Reducing the Risk: A School Leader's Guide to AIDS Education to identify your state coordinator).

CENTERS FOR DISEASE CONTROL

HIV/AIDS SURVEILLANCE

AIDS cases reported through July 1989 **Issued August 1989**

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Acquired immunodeficiency syndrome (AIDS) is a life-threatening manifestation of infection with the human immunodeficiency virus (HIV).

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • Public Health Service
Centers for Disease Control • Center for Infectious Diseases • Division of HIV/AIDS

The *HIV/AIDS Surveillance Report* is published each month by the Division of HIV/AIDS, Center for Infectious Diseases, Centers for Disease Control, Atlanta, GA 30333. An expanded, year-end edition is published each January. All data contained in the *Report* are provisional.

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Copies of the *HIV/AIDS Surveillance Report* are available free from the National AIDS Information Clearinghouse, P.O. Box 6003, Rockville, MD 20850. Individuals or organizations can be added to the mailing list by writing to Centers for Disease Control, Division of HIV/AIDS, Technical Information Activity, Mailstop G-29, Atlanta, GA 30333.

Figure 1. AIDS annual incidence rates per 100,000 population, for cases reported August 1988 through July 1989, United States

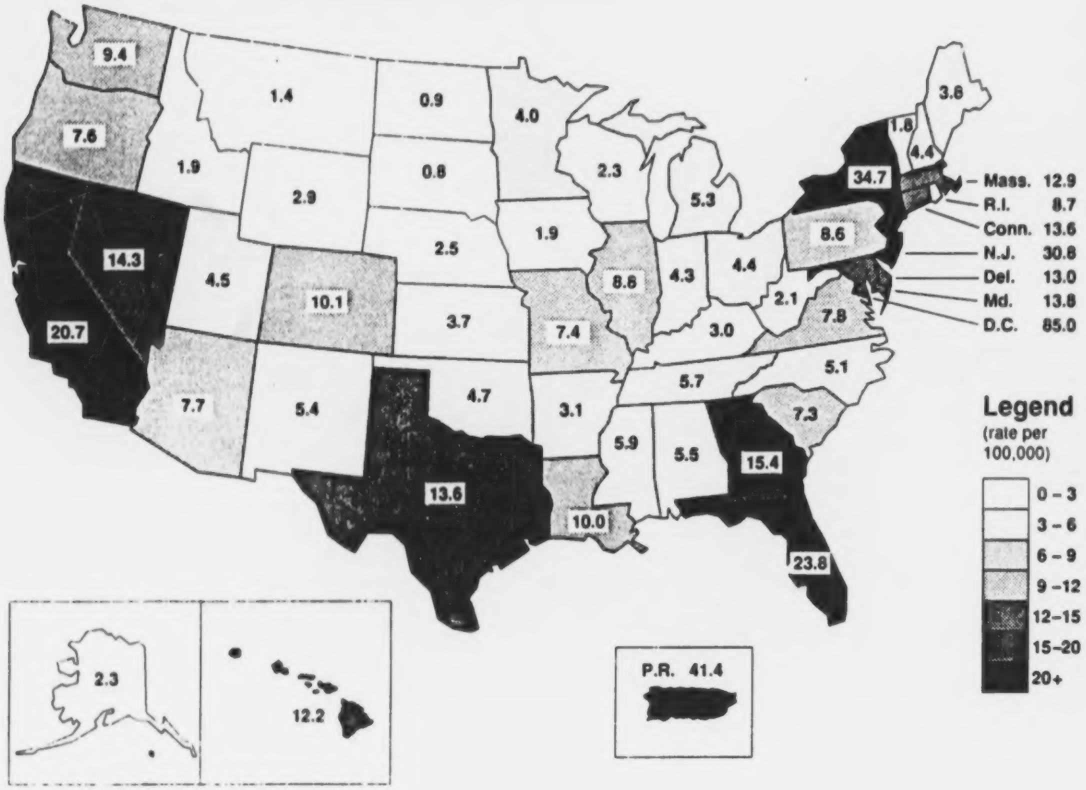
9.4
7.6
1.4
0.9
4.0
1.9
0.8
2.3
5.3
3.8
1.8
4.4
34.7
Mass. 12.9
R.I. 8.7
Conn. 13.6
N.J. 30.8
Del. 13.0
Md. 13.8
D.C. 85.0
2.9
1.9
8.6
14.3
4.5
10.1
2.5
8.8
4.3
4.4
2.1
7.8
20.7
3.7
7.4
3.0
5.7
5.1
7.7
5.4
4.7
3.1
7.3
5.9
5.5
15.4
13.6
10.0
23.8
2.3
12.2
P.R. 41.4
Legend
(rate per 100,000)
0 - 3
3 - 6
6 - 9
9 - 12
12-15
15-20
20+

Figure 2. Adult/adolescent and pediatric AIDS cases, reported August 1988 through July 1989, United States

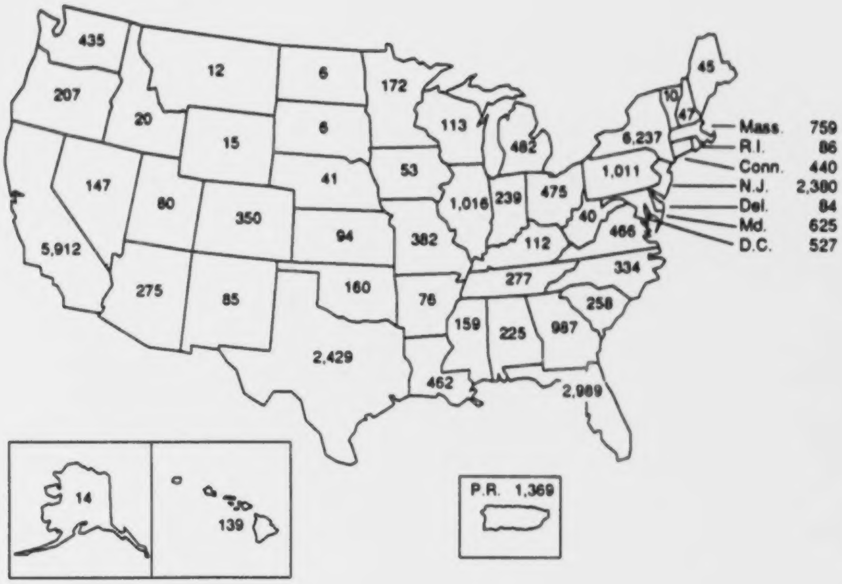
435
207
12
6
172
45
10
47
20
15
6
113
482
6,237
Mass. 759
R.I. 86
Conn. 440
N.J. 2,300
Del. 84
Md. 625
D.C. 527
147
80
350
41
53
1,016
239
475
1,011
40
466
5,912
94
382
112
334
275
85
160
277
76
258
159
225
987
2,429
462
2,989
14
139
P.R. 1,369

Figure 3. Pediatric AIDS cases, reported August 1988 through July 1989, United States

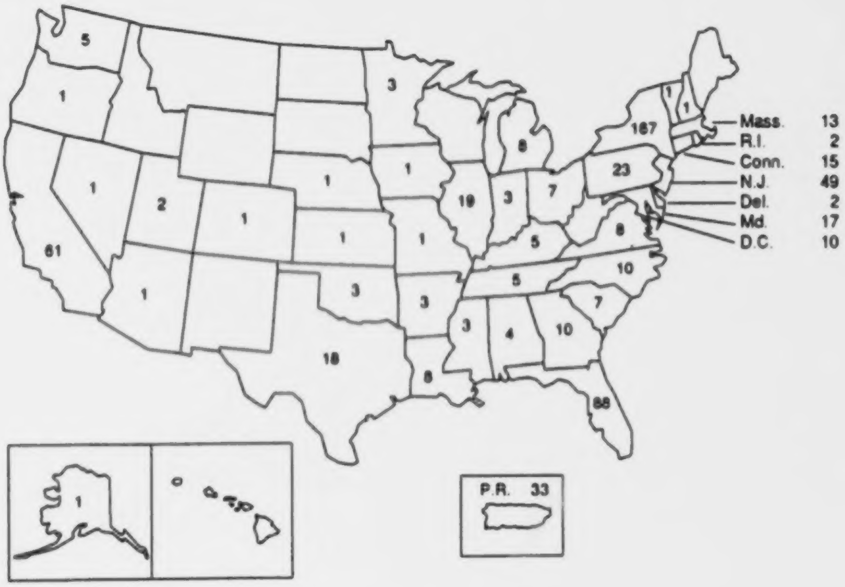
5
3
1
1
1
167
Mass. 13
R.I. 2
Conn. 15
N.J. 49
Del. 2
Md. 17
D.C. 10
8
1
1
23
1
2
1
19
3
7
61
1
1
5
8
10
1
3
3
5
7
3
4
10
18
8
88
1
P.R. 33

Table 1. **AIDS cases and annual incidence rates per 100,000 population, by state, reported August 1987 through July 1988 and August 1988 through July 1989; and cumulative totals, by state and age group, through July 1989**

State of residence	Aug. 1987-July 1988 No.	Aug. 1987-July 1988 Rate	Aug. 1988-July 1989 No.	Aug. 1988-July 1989 Rate	Cumulative totals Adults/adolescents	Cumulative totals Children < 13 years old	Cumulative totals Total
Alabama	191	4.7	225	5.5	550	15	565
Alaska	19	3.2	14	2.3	64	2	66
Arizona	300	8.6	275	7.7	817	4	821
Arkansas	78	3.3	76	3.1	215	3	218
California	5,539	19.8	5,912	20.7	20,334	144	20,478
Colorado	311	9.2	350	10.1	1,062	6	1,068
Connecticut	380	11.8	440	13.6	1,237	45	1,282
Delaware	58	9.0	84	13.0	190	4	194
District of Columbia	526	84.5	527	85.0	1,776	22	1,798
Florida	2,249	18.3	2,989	23.8	8,024	224	8,248
Georgia	667	10.6	987	15.4	2,480	33	2,513
Hawaii	94	8.4	139	12.2	387	2	389
Idaho	12	1.2	20	1.9	41	2	43
Illinois	945	8.2	1,016	8.8	2,969	44	3,013
Indiana	153	2.8	239	4.3	571	6	577
Iowa	36	1.3	53	1.9	137	3	140
Kansas	76	3.0	94	3.7	253	3	256
Kentucky	72	1.9	112	3.0	264	5	269
Louisiana	405	8.8	462	10.0	1,325	19	1,344
Maine	36	3.0	45	3.8	127	2	129
Maryland	583	12.9	625	13.8	1,792	43	1,835
Massachusetts	600	10.2	759	12.9	2,154	36	2,190
Michigan	340	3.7	482	5.3	1,192	19	1,211
Minnesota	154	3.6	172	4.0	540	5	545
Mississippi	106	4.0	159	5.9	315	6	321
Missouri	373	7.3	382	7.4	1,018	8	1,026
Montana	14	1.7	12	1.4	31	—	31
Nebraska	35	2.2	41	2.5	110	1	111
Nevada	139	13.8	147	14.3	373	3	376
New Hampshire	39	3.7	47	4.4	116	4	120
New Jersey	2,432	31.6	2,380	30.8	6,872	202	7,074
New Mexico	58	3.8	85	5.4	196	1	197
New York	5,926	33.1	6,237	34.7	22,912	512	23,424
North Carolina	300	4.6	334	5.1	875	20	895
North Dakota	2	0.3	6	0.9	15	—	15
Ohio	499	4.6	475	4.4	1,383	22	1,405
Oklahoma	139	4.1	160	4.7	425	9	434
Oregon	205	7.5	207	7.6	605	3	608
Pennsylvania	832	7.0	1,011	8.6	2,804	51	2,855
Rhode Island	80	8.1	86	8.7	250	6	256
South Carolina	144	4.1	258	7.3	546	15	561
South Dakota	5	0.7	6	0.8	16	—	16
Tennessee	266	5.5	277	5.7	646	10	656
Texas	1,906	10.9	2,429	13.6	6,913	56	6,969
Utah	63	3.6	80	4.5	203	5	208
Vermont	20	3.6	10	1.8	43	1	44
Virginia	295	5.0	466	7.8	1,205	23	1,228
Washington	431	9.4	435	9.4	1,340	8	1,348
West Virginia	16	0.8	40	2.1	88	2	90
Wisconsin	108	2.2	113	2.3	354	1	355
Wyoming	3	0.6	15	2.9	24	—	24
U.S. total	**28,260**	**11.5**	**31,995**	**12.9**	**98,179**	**1,660**	**99,839**
Guam	4	3.0	1	0.7	6	—	6
Pacific Islands, Trust Territory	—	—	1	0.7	1	—	1
Puerto Rico	953	28.9	1,369	41.4	2,635	73	2,708
Virgin Islands, U.S.	25	22.1	35	30.4	64	3	67
Total	**29,242**	**11.7**	**33,401**	**13.3**	**100,885**	**1,736**	**102,621**

Table 2. AIDS cases and annual incidence rates per 100,000 population, by metropolitan area with 500,000 or more population, reported August 1987 through July 1988 and August 1988 through July 1989; and cumulative totals, by area and age group, through July 1989

Metropolitan area of residence	Aug. 1987-July 1988		Aug. 1988-July 1989		Cumulative totals		
	No.	Rate	No.	Rate	Adults/adolescents	Children <13 years old	Total
Akron, Ohio	21	3.3	28	4.4	67	–	67
Albany-Schenectady, N.Y.	56	6.6	54	6.4	197	1	198
Allentown, Pa.	27	4.1	28	4.2	86	3	89
Anaheim, Calif.	231	10.3	289	12.7	842	8	850
Atlanta, Ga.	460	17.0	785	28.4	1,892	18	1,910
Austin, Tex.	90	11.2	155	18.5	382	4	386
Bakersfield, Calif.	21	4.0	24	4.4	60	–	60
Baltimore, Md.	308	13.5	389	17.0	967	30	997
Baton Rouge, La.	26	4.6	49	8.5	113	–	113
Bergen-Passaic, N.J.	324	24.8	242	18.5	891	24	915
Birmingham, Ala.	56	6.1	84	9.1	178	6	184
Boston, Mass.	474	12.7	608	16.2	1,727	29	1,756
Bridgeport, Conn.	118	14.2	135	16.2	370	13	383
Buffalo, N.Y.	42	4.4	40	4.2	131	–	131
Charleston, S.C.	36	7.0	53	10.1	130	–	130
Charlotte, N.C.	85	7.8	67	6.0	189	4	193
Chicago, Ill.	813	13.0	833	13.3	2,513	30	2,543
Cincinnati, Ohio	79	5.6	60	4.2	191	3	194
Cleveland, Ohio	138	7.5	125	6.8	384	5	389
Columbus, Ohio	113	8.6	114	8.6	309	2	311
Dallas, Tex.	528	20.8	583	22.4	1,743	7	1,750
Dayton, Ohio	37	4.0	56	6.0	137	3	140
Denver, Colo.	251	14.7	286	16.4	865	4	869
Detroit, Mich.	246	5.8	332	7.8	833	14	847
El Paso, Tex.	16	2.8	14	2.4	50	–	50
Fort Lauderdale, Fla.	362	30.4	451	37.3	1,300	20	1,320
Fort Worth, Tex.	113	8.5	139	10.1	365	1	366
Fresno, Calif.	32	5.2	49	7.7	110	1	111
Gary, Ind.	14	2.3	18	3.0	47	–	47
Grand Rapids, Mich.	11	1.7	30	4.5	60	1	61
Greensboro, N.C.	44	4.8	58	6.3	132	3	135
Greenville, S.C.	15	2.4	30	4.8	69	–	69
Harrisburg, Pa.	33	5.7	49	8.4	109	3	112
Hartford, Conn.	95	8.7	136	12.4	328	8	336
Honolulu, Hawaii	74	8.6	96	11.0	299	2	301
Houston, Tex.	860	25.2	875	25.0	2,990	25	3,015
Indianapolis, Ind.	65	5.3	114	9.2	251	1	252
Jacksonville, Fla.	156	17.6	160	17.6	381	10	391
Jersey City, N.J.	417	75.0	406	73.0	1,236	31	1,267
Kansas City, Mo.	217	14.1	195	12.6	547	3	550
Knoxville, Tenn.	26	4.3	28	4.6	72	–	72
Las Vegas, Nev.	108	17.8	106	17.0	267	3	270
Little Rock, Ark.	33	6.4	30	5.8	92	1	93
Los Angeles, Calif.	1,838	21.7	2,046	23.8	7,192	64	7,256
Louisville, Ky.	41	4.2	44	4.5	114	1	115
Memphis, Tenn.	93	9.6	80	8.2	206	4	210
Miami, Fla.	509	28.2	817	45.0	2,452	105	2,557
Middlesex, N.J.	192	20.0	201	20.7	555	19	574
Milwaukee, Wis.	63	4.6	68	5.0	212	–	212
Minneapolis-Saint Paul, Minn.	133	5.7	151	6.4	466	4	470
Monmouth-Ocean City, N.J.	146	15.0	165	16.7	387	14	401
Nashville, Tenn.	88	9.3	96	10.0	217	4	221
Nassau-Suffolk, N.Y.	283	10.6	320	12.0	1,057	34	1,091
New Haven, Conn.	132	16.8	122	15.4	389	24	413
New Orleans, La.	263	19.5	281	20.6	874	13	887
New York, N.Y.	5,091	59.5	5,412	63.0	20,099	462	20,561
Newark, N.J.	1,097	58.3	983	52.3	2,902	91	2,993
Norfolk, Va.	75	5.5	95	6.8	239	6	245

Table 2. AIDS cases and annual incidence rates per 100,000 population, by metropolitan area with 500,000 or more population, reported August 1987 through July 1988 and August 1988 through July 1989; and cumulative totals, by area and age group, through July 1989 — Continued

Metropolitan area of residence	Aug. 1987-July 1988		Aug. 1988-July 1989		Cumulative totals		
	No.	Rate	No.	Rate	Adults/ adolescents	Children <13 years old	Total
Oakland, Calif.	355	17.8	319	15.7	1,205	5	1,210
Oklahoma City, Okla.	42	4.1	18	1.7	136	—	136
Omaha, Neb.	25	4.0	29	4.6	77	—	77
Orlando, Fla.	122	12.6	161	16.1	386	4	390
Oxnard-Ventura, Calif.	34	5.3	41	6.3	97	—	97
Philadelphia, Pa.	649	13.4	725	15.0	2,140	35	2,175
Phoenix, Ariz.	231	11.2	187	8.7	589	2	591
Pittsburgh, Pa.	99	4.8	140	6.8	356	1	357
Portland, Oreg.	162	13.8	161	13.6	479	1	480
Providence, R.I.	72	8.0	76	8.4	217	5	222
Raleigh-Durham, N.C.	63	9.2	68	9.8	189	5	194
Richmond, Va.	51	6.2	98	11.8	231	1	232
Riverside-San Bernardino, Calif.	206	9.7	214	9.7	612	13	625
Rochester, N.Y.	81	8.2	65	6.6	229	1	230
Sacramento, Calif.	141	10.4	161	11.6	430	5	435
Saint Louis, Mo.	153	6.3	184	7.5	456	6	462
Salt Lake City, Utah	53	4.9	67	6.1	177	4	181
San Antonio, Tex.	32	2.4	342	25.2	488	7	495
San Diego, Calif.	417	18.1	455	19.3	1,372	11	1,383
San Francisco, Calif.	1,721	104.5	1,695	101.8	6,628	11	6,639
San Jose, Calif.	156	10.8	145	9.8	479	5	484
San Juan, P.R.	488	43.6	858	76.4	1,567	53	1,620
Scranton, Pa.	21	2.9	22	3.1	69	2	71
Seattle, Wash.	308	17.1	333	18.2	1,021	7	1,028
Springfield, Mass.	25	4.3	42	7.1	105	1	106
Syracuse, N.Y.	28	4.2	15	2.3	87	4	91
Tacoma, Wash.	29	5.3	26	4.7	79	1	80
Tampa, Fla.	353	17.6	393	19.1	972	17	989
Toledo, Ohio	22	3.6	16	2.7	58	1	59
Tucson, Ariz.	47	7.6	58	9.2	161	2	163
Tulsa, Okla.	43	5.6	49	6.3	123	2	125
Washington, D.C.	868	23.9	872	23.7	2,896	43	2,939
West Palm Beach, Fla.	265	32.9	305	36.6	864	33	897
Wilmington, Del.	44	7.9	68	12.1	148	3	151
Worcester, Mass.	39	5.9	33	4.9	104	2	106
Metropolitan area subtotal[1]	**24,764**	**17.4**	**27,725**	**19.3**	**86,490**	**1,459**	**87,949**
Non-metropolitan areas	**4,478**	**4.2**	**5,676**	**5.3**	**14,395**	**277**	**14,672**
Total	**29,242**	**11.7**	**33,401**	**13.3**	**100,885**	**1,736**	**102,621**

[1] Includes data from all metropolitan areas with 50,000 or more population.

Table 3. AIDS cases by age group, exposure category, and sex, reported August 1987 through July 1988 and August 1988 through July 1989; and cumulative totals, by age group and exposure category, through July 1989, United States

	Males		Females		Totals		
	Aug. 1987-July 1988	Aug. 1988-July 1989	Aug. 1987-July 1988	Aug. 1988-July 1989	Aug. 1987-July 1988	Aug. 1988-July 1989	Cumulative total
Adult/adolescent exposure category	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
Male homosexual/bisexual contact	16,837 (65)	18,734 (64)	–	–	16,837 (59)	18,734 (57)	61,614 (61)
Intravenous (IV) drug use (female and heterosexual male)	4,964 (19)	5,814 (20)	1,540 (54)	1,739 (51)	6,504 (23)	7,553 (23)	20,619 (20)
Male homosexual/bisexual contact and IV drug use	2,033 (8)	2,052 (7)	–	–	2,033 (7)	2,052 (6)	7,173 (7)
Hemophilia/coagulation disorder	284 (1)	310 (1)	5 (0)	9 (0)	289 (1)	319 (1)	968 (1)
Heterosexual contact:	518 (2)	665 (2)	826 (29)	1,010 (30)	1,344 (5)	1,675 (5)	4,595 (5)
Sex with IV drug user	*172*	*333*	*530*	*647*	*702*	*980*	*2,283*
Sex with bisexual male	–	–	*95*	*72*	*95*	*72*	*287*
Sex with person with hemophilia	*1*	*3*	*13*	*9*	*14*	*12*	*39*
Born in Pattern-II[1] country	*271*	*222*	*94*	*119*	*365*	*341*	*1,434*
Sex with person born in Pattern-II country	*19*	*11*	*6*	*8*	*25*	*19*	*66*
Sex with transfusion recipient with HIV infection	*6*	*8*	*14*	*23*	*20*	*31*	*67*
Sex with person with HIV infection, risk not specified	*49*	*88*	*74*	*132*	*123*	*220*	*419*
Receipt of transfusion of blood, blood components, or tissue[2]	536 (2)	432 (1)	310 (11)	319 (9)	846 (3)	751 (2)	2,472 (2)
Other/undetermined[3]	706 (3)	1,385 (5)	168 (6)	308 (9)	874 (3)	1,693 (5)	3,444 (3)
Adult/adolescent subtotal	25,878 (100)	29,392 (100)	2,849 (100)	3,385 (100)	28,727 (100)	32,777 (100)	100,885 (100)
Pediatric (<13 years old) exposure category							
Hemophilia/coagulation disorder	29 (10)	33 (10)	–	1 (0)	29 (6)	34 (5)	98 (6)
Mother with/at risk for AIDS/HIV infection:	211 (74)	259 (75)	195 (85)	251 (90)	406 (79)	510 (82)	1,385 (80)
IV drug use	*108*	*130*	*103*	*107*	*211*	*237*	*712*
Sex with IV drug user	*44*	*56*	*33*	*58*	*77*	*114*	*280*
Sex with bisexual male	*3*	*5*	*8*	*3*	*11*	*8*	*30*
Sex with person with hemophilia	*3*	–	*2*	*1*	*5*	*1*	*7*
Born in Pattern-II country	*19*	*28*	*15*	*26*	*34*	*54*	*154*
Sex with person born in Pattern-II country	*1*	*2*	–	*2*	*1*	*4*	*6*
Sex with transfusion recipient with HIV infection	–	*3*	*1*	*4*	*1*	*7*	*8*
Sex with person with HIV infection, risk not specified	*10*	*13*	*6*	*11*	*16*	*24*	*54*
Receipt of transfusion of blood, blood components, or tissue	*3*	*2*	*11*	*7*	*14*	*9*	*30*
Has HIV infection, risk not specified	*20*	*20*	*16*	*32*	*36*	*52*	*104*
Receipt of transfusion of blood, blood components, or tissue	39 (14)	37 (11)	27 (12)	15 (5)	66 (13)	52 (8)	196 (11)
Undetermined	7 (2)	16 (5)	7 (3)	12 (4)	14 (3)	28 (4)	57 (3)
Pediatric subtotal	286 (100)	345 (100)	229 (100)	279 (100)	515 (100)	624 (100)	1,736 (100)
Total	**26,164**	**29,737**	**3,078**	**3,664**	**29,242**	**33,401**	**102,621**

[1] See technical notes.

[2] Includes 1 tissue recipient and 6 transfusion recipients who received blood screened for HIV antibody.

[3] "Other" is 1 health-care worker who seroconverted to HIV and developed AIDS after needlestick exposure to HIV-infected blood. "Undetermined" includes patients under investigation; patients who died, were lost to follow-up, or refused interview; and patients whose mode of exposure to HIV remains undetermined after investigation.

Table 4. AIDS cases by age group, exposure category, and race/ethnicity, reported through July 1989, United States

Adult/adolescent exposure category	**White, not Hispanic** No. (%)	**Black, not Hispanic** No. (%)	**Hispanic** No. (%)	**Asian/Pacific Islander** No. (%)	**American Indian/ Alaskan Native** No. (%)	**Total**[4] No. (%)
Male homosexual/bisexual contact	44,607 (77)	9,944 (37)	6,419 (42)	460 (76)	65 (51)	61,614 (61)
Intravenous (IV) drug use (female and heterosexual male)	4,150 (7)	10,283 (38)	6,090 (40)	21 (3)	21 (17)	20,619 (20)
Male homosexual/bisexual contact and IV drug use	4,254 (7)	1,850 (7)	1,033 (7)	9 (1)	18 (14)	7,173 (7)
Hemophilia/coagulation disorder	810 (1)	61 (0)	73 (0)	14 (2)	6 (5)	968 (1)
Heterosexual contact:	918 (2)	2,908 (11)	734 (5)	20 (3)	8 (6)	4,595 (5)
Sex with IV drug user	*514*	*1,155*	*601*	*8*	*3*	*2,283*
Sex with bisexual male	*151*	*92*	*38*	*4*	*1*	*287*
Sex with person with hemophilia	*34*	*3*	*1*	*1*	—	*39*
Born in Pattern-II[1] *country*	*3*	*1,416*	*10*	*2*	—	*1,434*
Sex with person born in Pattern-II country	*18*	*44*	*4*	—	—	*66*
Sex with transfusion recipient with AIDS/HIV infection	*51*	*8*	*5*	*2*	—	*67*
Sex with person with HIV infection, risk not specified	*147*	*190*	*75*	*3*	*4*	*419*
Receipt of transfusion of blood, blood components, or tissue[2]	1,816 (3)	377 (1)	224 (1)	46 (8)	3 (2)	2,472 (2)
Other/undetermined[3]	1,293 (2)	1,326 (5)	751 (5)	36 (6)	6 (5)	3,444 (3)
Adult/adolescent subtotal	57,848(100)	26,749 (100)	15,324(100)	606(100)	127(100)	100,885(100)
Pediatric (<13 years old) exposure category						
Hemophilia/coagulation disorder	69 (18)	12 (1)	14 (3)	3 (33)	—	98 (6)
Mother with/at risk for AIDS/HIV infection:	203 (52)	828 (90)	343 (84)	3 (33)	4(100)	1,385 (80)
IV drug use	*96*	*419*	*193*	*1*	*2*	*712*
Sex with IV drug user	*43*	*135*	*101*	—	—	*280*
Sex with bisexual male	*11*	*15*	*4*	—	—	*30*
Sex with person with hemophilia	*5*	*1*	*1*	—	—	*7*
Born in Pattern-II country	*2*	*151*	*1*	—	—	*154*
Sex with person born in Pattern-II country	—	*5*	—	—	—	*6*
Sex with transfusion recipient with HIV infection	*5*	*2*	*1*	—	—	*8*
Sex with person with HIV infection, risk not specified	*9*	*24*	*18*	*1*	*1*	*54*
Receipt of transfusion of blood, blood components, or tissue	*9*	*12*	*9*	—	—	*30*
Has HIV infection, risk not specified	*23*	*64*	*15*	*1*	*1*	*104*
Receipt of transfusion of blood, blood components, or tissue	108 (28)	45 (5)	40 (10)	3 (33)	—	196 (11)
Undetermined	12 (3)	33 (4)	12 (3)	—	—	57 (3)
Pediatric subtotal	392(100)	918 (100)	409(100)	9(100)	4(100)	1,736(100)
Total	**58,240**	**27,667**	**15,733**	**615**	**131**	**102,621**

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[1] See technical notes.

[2] Includes 1 tissue recipient and 6 transfusion recipients who received blood screened for HIV antibody.

[3] "Other" is 1 health-care worker who seroconverted to HIV and developed AIDS after needlestick exposure to HIV-infected blood. "Undetermined" includes patients under investigation; patients who died, were lost to follow-up, or refused interview; and patients whose mode of exposure to HIV remains undetermined after investigation.

[4] Includes 235 persons whose race/ethnicity is unknown.

Table 5. Adult/adolescent AIDS cases by sex, exposure category, and race/ethnicity, reported through July 1989, United States

Male exposure category	White, not Hispanic	Black, not Hispanic	Hispanic	Asian/Pacific Islander	American Indian/ Alaskan Native	Total[4]
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
Male homosexual/bisexual contact	44,607 (81)	9,944 (45)	6,419 (47)	460 (83)	65 (61)	61,614 (67)
Intravenous (IV) drug use (heterosexual)	3,140 (6)	7,598 (34)	5,157 (38)	11 (2)	9 (8)	15,958 (17)
Male homosexual/bisexual contact and IV drug use	4,254 (8)	1,850 (8)	1,033 (8)	9 (2)	18 (17)	7,173 (8)
Hemophilia/coagulation disorder	789 (1)	58 (0)	72 (1)	14 (3)	6 (6)	943 (1)
Heterosexual contact:	287 (1)	1,492 (7)	126 (1)	4 (1)	1 (1)	1,912 (2)
Sex with IV drug user	*187*	*348*	*90*	*1*	*1*	*627*
Sex with person with hemophilia	*3*	*1*	–	–	–	*4*
Born in Pattern-II[1] country	*2*	*1,051*	*7*	*2*	–	*1,063*
Sex with person born in Pattern-II country	*18*	*17*	*4*	–	–	*39*
Sex with transfusion recipient with HIV infection	*10*	*5*	–	*1*	–	*17*
Sex with person with HIV infection, risk not specified	*67*	*70*	*25*	–	–	*162*
Receipt of transfusion of blood, blood components, or tissue[2]	1,180 (2)	190 (1)	130 (1)	30 (5)	1 (1)	1,537 (2)
Other/undetermined[3]	1,093 (2)	975 (4)	639 (5)	28 (5)	6 (6)	2,765 (3)
Male subtotal	55,350 (100)	22,107 (100)	13,576 (100)	556 (100)	106 (100)	91,902 (100)
Female exposure category						
IV drug use	1,010 (40)	2,685 (58)	933 (53)	10 (20)	12 (57)	4,661 (52)
Hemophilia/coagulation disorder	21 (1)	3 (0)	1 (0)	–	–	25 (0)
Heterosexual contact:	631 (25)	1,416 (31)	608 (35)	16 (32)	7 (33)	2,683 (30)
Sex with IV drug user	*327*	*807*	*511*	*7*	*2*	*1,656*
Sex with bisexual male	*151*	*92*	*38*	*4*	*1*	*287*
Sex with person with hemophilia	*31*	*2*	*1*	*1*	–	*35*
Born in Pattern-II country	*1*	*365*	*3*	–	–	*371*
Sex with person born in Pattern-II country	–	*27*	–	–	–	*27*
Sex with transfusion recipient with HIV infection	*41*	*3*	*5*	*1*	–	*50*
Sex with person with HIV infection, risk not specified	*80*	*120*	*50*	*3*	*4*	*257*
Receipt of transfusion of blood, blood components, or tissue	636 (25)	187 (4)	94 (5)	16 (32)	2 (10)	935 (10)
Other/undetermined	200 (8)	351 (8)	112 (6)	8 (16)	–	679 (8)
Female subtotal	2,498 (100)	4,642 (100)	1,748 (100)	50 (100)	21 (100)	8,983 (100)
Total	**57,848**	**26,749**	**15,324**	**606**	**127**	**100,885**

[1] See technical notes.

[2] Includes 1 tissue recipient and 6 transfusion recipients who received blood screened for HIV antibody.

[3] "Other" is 1 health-care worker who seroconverted to HIV and developed AIDS after needlestick exposure to HIV-infected blood. "Undetermined" includes patients under investigation; patients who died, were lost to follow-up, or refused interview; and patients whose mode of exposure to HIV remains undetermined after investigation.

[4] Includes 207 males and 24 females whose race/ethnicity is unknown.

Table 6. AIDS cases by sex, age at diagnosis, and race/ethnicity, reported through July 1989, United States

Males	White, not Hispanic		Black, not Hispanic		Hispanic		Asian/Pacific Islander		American Indian/ Alaskan Native		Total[1]	
Age at diagnosis (years)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Under 5	132	(0)	415	(2)	194	(1)	3	(1)	2	(2)	748	(1)
5-12	110	(0)	55	(0)	36	(0)	3	(1)	—		205	(0)
13-19	163	(0)	94	(0)	58	(0)	5	(1)	2	(2)	323	(0)
20-24	2,047	(4)	1,127	(5)	660	(5)	24	(4)	8	(7)	3,873	(4)
25-29	8,438	(15)	3,709	(16)	2,366	(17)	74	(13)	17	(16)	14,627	(16)
30-34	13,103	(24)	5,786	(26)	3,583	(26)	123	(22)	30	(28)	22,671	(24)
35-39	12,168	(22)	5,147	(23)	2,977	(22)	121	(22)	20	(19)	20,482	(22)
40-44	8,190	(15)	2,807	(12)	1,867	(14)	78	(14)	12	(11)	12,991	(14)
45-49	4,791	(9)	1,578	(7)	934	(7)	63	(11)	9	(8)	7,391	(8)
50-54	2,777	(5)	912	(4)	548	(4)	30	(5)	3	(3)	4,282	(5)
55-59	1,796	(3)	531	(2)	343	(2)	18	(3)	3	(3)	2,701	(3)
60-64	975	(2)	262	(1)	144	(1)	6	(1)	2	(2)	1,393	(2)
65 or older	902	(2)	154	(1)	96	(1)	14	(2)	—		1,168	(1)
Male subtotal	55,592	(100)	22,577	(100)	13,806	(100)	562	(100)	108	(100)	92,855	(100)

Females												
Age at diagnosis (years)												
Under 5	126	(5)	397	(8)	153	(8)	1	(2)	2	(9)	680	(7)
5-12	24	(1)	51	(1)	26	(1)	2	(4)	—		103	(1)
13-19	16	(1)	46	(1)	12	(1)	1	(2)	1	(4)	76	(1)
20-24	180	(7)	292	(6)	148	(8)	2	(4)	1	(4)	627	(6)
25-29	487	(18)	973	(19)	435	(23)	5	(9)	4	(17)	1,912	(20)
30-34	573	(22)	1,436	(28)	490	(25)	14	(26)	8	(35)	2,527	(26)
35-39	361	(14)	973	(19)	339	(18)	5	(9)	3	(13)	1,685	(17)
40-44	206	(8)	452	(9)	166	(9)	9	(17)	1	(4)	834	(9)
45-49	106	(4)	195	(4)	67	(3)	4	(8)	—		374	(4)
50-54	90	(3)	112	(2)	34	(2)	3	(6)	1	(4)	240	(2)
55-59	101	(4)	64	(1)	25	(1)	1	(2)	—		191	(2)
60-64	104	(4)	46	(1)	15	(1)	3	(6)	1	(4)	169	(2)
65 or older	274	(10)	53	(1)	17	(1)	3	(6)	1	(4)	348	(4)
Female subtotal	2,648	(100)	5,090	(100)	1,927	(100)	53	(100)	23	(100)	9,766	(100)
Total	**58,240**		**27,667**		**15,733**		**615**		**131**		**102,621**	

[1] Includes 235 persons whose race/ethnicity is unknown.

Table 7. AIDS deaths and case-fatality rates, by half-year of diagnosis and age group, diagnosed through July 1989, United States

	Adults/adolescents			Children <13 years old		
Half-year of diagnosis	**Cases**	**Deaths**	**Case-fatality rate**	**Cases**	**Deaths**	**Case-fatality rate**
Before 1981	77	63	81.8	6	4	66.7
1981 Jan.-June	88	81	92.0	8	5	62.5
July-Dec.	194	178	91.8	5	5	100.0
1982 Jan.-June	381	347	91.1	13	10	76.9
July-Dec.	657	588	89.5	14	11	78.6
1983 Jan.-June	1,246	1,139	91.4	34	30	88.2
July-Dec.	1,608	1,461	90.9	40	28	70.0
1984 Jan.-June	2,501	2,153	86.1	47	39	83.0
July-Dec.	3,292	2,865	87.0	60	44	73.3
1985 Jan.-June	4,679	4,022	86.0	93	62	66.7
July-Dec.	6,044	5,065	83.8	127	94	74.0
1986 Jan.-June	7,871	6,290	79.9	129	87	67.4
July-Dec.	9,429	6,952	73.7	158	100	63.3
1987 Jan.-June	11,889	7,980	67.1	199	115	57.8
July-Dec.	13,016	7,062	54.3	228	116	50.9
1988 Jan.-June	14,020	5,911	42.2	191	81	42.4
July-Dec.	13,452	4,318	32.1	239	71	29.7
1989 Jan.-June	10,370	1,970	19.0	145	42	29.0
July-July	71	2	2.8	–	–	
Total	**100,885**	**58,447**	**57.9**	**1,736**	**944**	**54.4**

Table 8. AIDS cases by year of diagnosis and definition category, diagnosed through July 1989, United States

	Year of diagnosis					
	Before Mar. 1985	**Mar. 1985-Feb. 1986**	**Mar. 1986-Feb. 1987**	**Mar. 1987-Feb. 1988**	**Mar. 1988-Feb. 1989**	**Cumulative total**
Definition category[1]	**No. (%)**	**No. (%)**	**No. (%)**	**No. (%)**	**No. (%)**	**No. (%)**
Pre-1987 definition	15,711 (98)	13,419 (91)	19,412 (87)	20,155 (73)	15,163 (69)	83,860 (82)
1987 definition:	334 (2)	1,290 (9)	2,911 (13)	7,454 (27)	6,772 (31)	18,761 (18)
Specific disease presumptively diagnosed	*161*	*702*	*1,551*	*4,095*	*3,780*	*10,289*
Specific disease definitively diagnosed	*98*	*189*	*394*	*555*	*434*	*1,670*
HIV encephalopathy	*27*	*108*	*362*	*969*	*763*	*2,229*
HIV wasting syndrome	*48*	*291*	*604*	*1,835*	*1,795*	*4,573*
Total	**16,045 (100)**	**14,709 (100)**	**22,323 (100)**	**27,609 (100)**	**21,935 (100)**	**102,621 (100)**

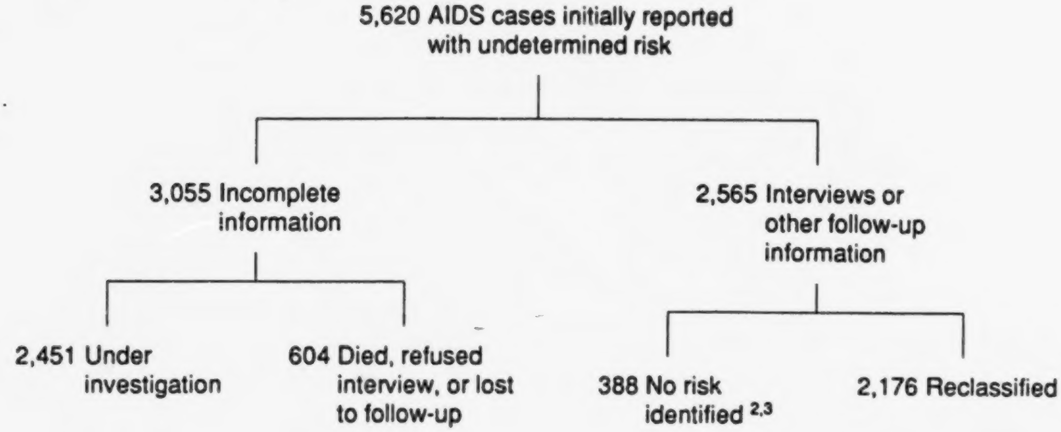
---

[1] Persons who meet the criteria for more than one definition category are classified in the definition category listed first.

Table 9. Adult/adolescent AIDS cases by single and multiple exposure categories, reported through July 1989, United States

	AIDS cases	
Exposure category	**No.**	**(%)**
Single mode of exposure		
Male homosexual/bisexual contact	59,160	(59)
Intravenous (IV) drug use (female and heterosexual male)	17,664	(18)
Hemophilia/coagulation disorder	574	(1)
Heterosexual contact	4,355	(4)
Receipt of transfusion of blood, blood component, or tissue	2,472	(2)
Other/undetermined	3,444	(3)
Single mode of exposure subtotal	**87,669**	**(87)**
Multiple modes of exposure		
Male homosexual/bisexual contact; IV drug use	6,490	(6)
Male homosexual/bisexual contact; hemophilia	41	(0)
Male homosexual/bisexual contact; heterosexual contact	1,149	(1)
Male homosexual/bisexual contact; receipt of transfusion	1,174	(1)
IV drug use; hemophilia	26	(0)
IV drug use; heterosexual contact	2,255	(2)
IV drug use; receipt of transfusion	508	(1)
Hemophilia; heterosexual contact	5	(0)
Hemophilia; receipt of transfusion	384	(0)
Heterosexual contact; receipt of transfusion	240	(0)
Male homosexual/bisexual contact; IV drug use; hemophilia	16	(0)
Male homosexual/bisexual contact; IV drug use; heterosexual contact	445	(0)
Male homosexual/bisexual contact; IV drug use; receipt of transfusion	193	(0)
Male homosexual/bisexual contact; hemophilia; heterosexual contact	2	(0)
Male homosexual/bisexual contact; hemophilia; receipt of transfusion	27	(0)
Male homosexual/bisexual contact; heterosexual contact; receipt of transfusion	60	(0)
IV drug use; hemophilia; heterosexual contact	8	(0)
IV drug use; hemophilia; receipt of transfusion	18	(0)
IV drug use; heterosexual contact; receipt of transfusion	136	(0)
Hemophilia; heterosexual contact; receipt of transfusion	5	(0)
Male homosexual/bisexual contact; IV drug use; hemophilia; receipt of transfusion	10	(0)
Male homosexual/bisexual contact; IV drug use; heterosexual contact; receipt of transfusion	19	(0)
Male homosexual/bisexual contact; hemophilia; heterosexual contact; receipt of transfusion	1	(0)
IV drug use; hemophilia; heterosexual contact; receipt of transfusion	4	(0)
Multiple modes of exposure subtotal	**13,216**	**(13)**
Total	**100,885**	**(100)**

Figure 4. Results of investigations of adult/adolescent AIDS cases with undetermined risk, reported through July 1989[1]


5,620 AIDS cases initially reported with undetermined risk
3,055 Incomplete information
2,565 Interviews or other follow-up information
2,451 Under investigation
604 Died, refused interview, or lost to follow-up
388 No risk identified [2,3]
2,176 Reclassified

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[1] Excludes 57 children under 13 years of age who have an undetermined risk: 49 children are under investigation and 8 have died, refused interview, or were lost to follow-up. An additional 55 children who were initially reported with an undetermined risk have been reclassified after investigation.

[2] **Health-care workers.** Included among the 388 adults/adolescents whose mode of exposure remains undetermined after investigation are 55 health-care workers; 23 (55%) of 42 workers who responded to a standardized questionnaire reported needlesticks and/or mucous membrane exposures to blood and other body fluids of patients. None of the patients was known to be infected with HIV at the time of the exposure and none of the health-care workers was evaluated at the time of the exposure to document seroconversion to HIV antibody. Not included in this figure is 1 health-care worker who seroconverted to HIV and developed AIDS after a needlestick exposure to HIV-infected blood and is classified as "other." See *MMWR*, "Update: Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus Infection Among Health-Care Workers," (April 22,1988) 37:229-234,239.

[3] **Heterosexual transmission.** 272 of the 388 patients who had no risk identified after follow-up responded to a standardized questionnaire; 89 (37%) of 241 persons responding to questions related to sexually transmitted disease gave a history of such disease and 57 (33%) of 172 interviewed men reported sexual contact with a prostitute. Some of these persons may represent unreported or unrecognized heterosexual transmission of HIV. See *MMWR*, "Update: Heterosexual Transmission of AIDS and HIV Infection — U.S.," (June 23, 1989) 38:423-424,429-434.

Technical notes

Surveillance and reporting of AIDS

All 50 states, the District of Columbia, and U.S. dependencies and possessions report AIDS cases to CDC using a uniform case definition and case report form. The original definition was modified in 1985 (*MMWR* 1985;34:373-5) and again in 1987 (*MMWR* 1987;36 [suppl. no. 1S]:1S-15S). The revisions incorporated a broader range of AIDS-indicator diseases and conditions and used human immunodeficiency virus (HIV) diagnostic tests to improve the sensitivity and specificity of the definition. For persons with laboratory-confirmed HIV infection, the 1987 revision incorporated HIV encephalopathy, wasting syndrome, and other indicator diseases that are diagnosed presumptively (i.e., without confirmatory laboratory evidence of the opportunistic disease). AIDS cases that meet the criteria of both the pre-1987 and 1987 definitions are classified in the pre-1987 definition category. The CDC case report form includes demographic, clinical, laboratory, and exposure information.

Each issue of this update includes information received by CDC through the last day of the reporting month. Data are tabulated by date of report to CDC unless otherwise noted. Data for U.S. dependencies and possessions are included in the totals unless otherwise noted.

Reporting by age is based on the person's age at the time of diagnosis of AIDS: adult/adolescent cases include persons 13 years of age and older; pediatric cases include children under 13 years of age.

Metropolitan areas are defined as the Metropolitan Statistical Areas (MSA) for all areas except the 6 New England states. For these states, the New England County Metropolitan Areas (NECMA) are used. Metropolitan areas are named for a central city in the MSA or NECMA and may include several counties. For example, AIDS cases and incidence rates presented for the District of Columbia in Table 1 include only persons residing within the geographic boundaries of the District. AIDS cases and incidence rates for Washington, D.C., in Table 2 include persons residing within several counties in the MSA. State or metropolitan area data tabulations are based on the person's residence at diagnosis of the first AIDS-indicator disease.

Data in this report are provisional; completeness of reporting to state and local health departments varies. In addition, multiple routes of exposure, opportunistic diseases diagnosed after the initial case report was submitted to CDC, and vital status may not be determined or reported for all cases. Caution should be used in interpreting case-fatality rates because reporting of deaths is known to be incomplete.

Exposure categories

For surveillance purposes, AIDS cases are counted only once in a hierarchy of exposure categories. Persons with more than one reported mode of exposure to HIV are classified in the exposure category listed first in the hierarchy, except for persons with a history of both homosexual/bisexual contact and intravenous drug use. They make up a separate exposure category.

"Heterosexual contact" cases include persons who report either specific heterosexual contact with a person with, or at increased risk for, HIV infection (e.g., an intravenous drug user), or persons presumed to have acquired HIV infection through heterosexual contact because they were born in countries with a distinctive pattern of transmission termed "Pattern II" by the World Health Organization (*MMWR* 1988;37:286-8,293-5). Pattern II is observed in areas of central, eastern, and southern Africa and in some Caribbean countries. In these countries, most of the reported cases occur in heterosexuals; the male-to-female ratio is approximately 1:1; and perinatal transmission is more common than in other areas. Intravenous drug use and homosexual transmission either do not occur or occur at a low level.

"Undetermined" cases are in persons with no reported history of exposure to HIV through any of the routes listed in the hierarchy of exposure categories. Undetermined cases include persons who are currently under investigation by local health department officials; persons whose exposure history is incomplete because of death, refusal to be interviewed, or loss to follow-up; and persons who were interviewed or for whom other follow-up information was available and no exposure mode was identified. Persons who have an exposure mode identified at the time of follow-up are reclassified into the appropriate exposure category.

Rates

Rates are on an annual basis per 100,000 population. The denominator for computing the rates is based on population estimates derived from 1980 census data and post-census population estimates. Each 12-month rate is the number of cases for a 12-month period divided by the estimated midyear 1988 or 1989 population multiplied by 100,000.

Case-fatality rates are on a semiannual basis by date of diagnosis. Each 6-month case-fatality rate is the sum of fatal cases reported per number of cases diagnosed in that period. Deaths reported for cases diagnosed in a particular half-year period may have occurred after that period.

"First 100,000 Cases of Acquired Immunodeficiency Syndrome -- United States,"
Morbidity and Mortality Weekly Report, August 18, 1989, Vol. 38, No. 32

Summary

This article provides a brief epidemiological history of AIDS in the United States to date. Trends identified are:

- Increasing proportion of reported AIDS cases among intravenous drug users (IVDUs), their sex partners, and their children;
- Increasing proportion of reported AIDS cases among women;
- Disproportionate representation of blacks and Hispanics in reported AIDS cases;
- Increasing proportion of reported AIDS cases from smaller cities and rural areas.

The "Editorial Note" emphasizes that the 100,000 cases of AIDS reported as of July 1989 represent only the minimum number of persons with severe conditions related to infection with the human immunodeficiency virus (HIV) and are only an indication of the larger epidemic of HIV infection.

This information can be used to reinforce the long-term and widespread implications of the AIDS epidemic.

Current Trends

First 100,000 Cases of Acquired Immunodeficiency Syndrome — United States

In June 1981, the first cases of the illness now known as acquired immunodeficiency syndrome (AIDS) were reported from Los Angeles in five young homosexual men diagnosed with *Pneumocystis carinii* pneumonia and other opportunistic infections (*1*). Since then, state and territorial health departments have reported >100,000 cases of AIDS and >59,000 AIDS-related deaths to CDC. AIDS is now a major cause of morbidity and mortality in children and young adults in the United States, ranking 15th among leading causes of death in 1988 (*2*) and seventh among estimated years of potential life lost before age 65 in 1987 (*3*). The first 50,000 cases of AIDS were reported to CDC from 1981 to 1987; the second 50,000 were reported between December 1987 and July 1989.

Although homosexual/bisexual men still account for most reported AIDS cases, intravenous-drug users (IVDUs), their sex partners, and their children represent an increasing proportion of all cases. Of AIDS cases reported before 1985, 63% were homosexual/bisexual men with no history of IV-drug use, 18% were female or heterosexual male IVDUs, and 2% were sex partners or children of IVDUs or their sex partners. In contrast, of the AIDS cases reported in the first 6 months of 1989, 56% were homosexual/bisexual men with no history of IV-drug use, 23% were female or heterosexual male IVDUs, and 4% were sex partners or children of IVDUs or their sex partners. The proportion of AIDS cases among women has also increased from 7% of cases reported before 1985 to 11% of cases reported in the first 6 months of 1989. Blacks and Hispanics continue to be disproportionately represented among all persons with AIDS and particularly among IVDUs with AIDS (Table 1). Although most AIDS cases are reported from large metropolitan areas, an increasing proportion are being reported from smaller cities and rural areas. Metropolitan statistical areas with populations ≤500,000 reported 10% of all U.S. cases before 1985, compared with 19% in 1988.

AIDS — Continued

Reported by: AIDS Program, Center for Infectious Diseases, CDC.

Editorial Note: The 100,000 AIDS cases reported in the United States as of July 1989 represent the minimum number of persons with severe human immunodeficiency virus (HIV)-related disease. Because of the combination of underdiagnosis and underreporting of AIDS cases and severe manifestations of HIV infection that do not meet the CDC AIDS surveillance case definition, reported AIDS cases underestimate the number of persons severely affected by HIV since 1981. The completeness of diagnosis and reporting of AIDS cases varies by geographic region and patient population; however, mortality studies suggest that 70%–90% of HIV-related deaths are identified through national surveillance of AIDS (*4*).

The number of AIDS cases are one indication of the larger epidemic of HIV infection. An estimated 1–1.5 million persons are infected with HIV in the United States (*5*), with recent seroprevalence studies suggesting that the actual number is closer to the lower end of this range (*6*). A cohort study of homosexual/bisexual men in San Francisco suggests that 54% of infected persons will develop AIDS within 10 years of infection (*7*) and that up to 99% will eventually develop AIDS (*8*). Therefore, the number of persons with AIDS and other severe manifestations of HIV infection will continue to increase.

AIDS is reportable in all 50 states, the District of Columbia, and U.S. territories. AIDS surveillance has been crucial in identifying characteristics of persons at risk for the disease and modes of transmission and remains extremely important in monitoring trends in severe HIV-related disease, projecting future numbers of AIDS cases and HIV-infected persons, and targeting resources for prevention and treatment efforts. Because persons with AIDS require a broad range of medical services, documentation of these cases is also important in determining current and future health-care needs and costs. AIDS surveillance data together with information from the HIV family of surveys (*6*) and HIV infection reporting (*9*) are important components of public health programs directed toward controlling HIV infection and assist in providing the most accurate picture of the HIV epidemic in the United States.

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TABLE 1. Percentage distribution by racial/ethnic groups comparing population, AIDS cases, and AIDS cases associated with intravenous-drug users (IVDU) — United States,[*] 1981–1989

		AIDS cases			
Race/Ethnicity	1980 U.S. population[†]	Cumulative[*] (n=97,110)	IVDU[§] (n=18,540)	Heterosexual IVDU contact (n=2,067)	Children and sex partners of IVDU (n=906)
White	79.6%	58.5%	21.8%	24.2%	14.7%
Black	11.5%	27.7%	54.0%	54.0%	60.0%
Hispanic	6.4%	13.1%	24.1%	21.2%	25.0%
Asian/Pacific Islander	1.8%	0.6%	0.1%	0.4%	0.1%
American Indian/ Alaskan Native	0.7%	0.1%	0.1%	0.1%	0.2%

[*] Excluding U.S. territories.
[†] 1980 U.S. Census.
[§] Female or heterosexual male IVDU.

AIDS – Continued

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"Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health-Care and Public Safety Workers," Morbidity and Mortality Weekly Report, June 23, 1989, Vol. 38, No. S-6

Summary

Although these guidelines are designed for health-care and public-safety workers, they are based on current knowledge about transmission of HIV and HBV that can be useful in policy development and administration in settings where there is less risk of transmission of these viruses, such as in schools. Key points include:

- The potential for HBV transmission in the workplace setting is greater than for HIV;
- The modes of transmission of HBV and HIV are similar;
- Blood is the single most important source of HIV and HBV in the workplace setting; the potential for salivary transmission of HIV is remote.
- All patients [students, employees] should be assumed to be infectious for HIV and other blood-borne pathogens and "universal precautions" should be used whenever contact with blood, semen, or any body fluid visibly contaminated with blood occurs.
- Employers should develop standard procedures, provide training and education in these procedures, ensure compliance, provide protective equipment, and redesign workplaces as necessary.
- People who are exposed to blood should be counseled regarding risk of infection and be evaluated for evidence of HIV infection as soon as possible after exposure.

These guidelines describe procedures for hand washing, cleaning and decontaminating spills of blood, disposal of infectious waste, and other precautions.

This information can be used to reinforce how difficult it is to transmit HIV through casual contact and how important it is to adopt policies that are based on accurate medical knowledge and to educate employees about risk reduction in the workplace.

June 23, 1989 / Vol. 38 / No. S-6

MORBIDITY AND MORTALITY WEEKLY REPORT

Recommendations and Reports

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Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health-Care and Public-Safety Workers

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Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health-Care and Public-Safety Workers

A Response to P.L. 100-607
The Health Omnibus Programs Extension
Act of 1988

U.S. Department of Health and Human Services
Public Health Service
Centers for Disease Control
Atlanta, Georgia

February 1989

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I. Introduction

A. Background

This document is a response to recently enacted legislation, Public Law 100-607, The Health Omnibus Programs Extension Act of 1988, Title II, Programs with Respect to Acquired Immune Deficiency Syndrome ("AIDS Amendments of 1988"). Subtitle E, General Provisions, Section 253(a) of Title II specifies that "the Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control, shall develop, issue, and disseminate guidelines to all health workers, public safety workers (including emergency response employees) in the United States concerning –

(1) methods to reduce the risk in the workplace of becoming infected with the etiologic agent for acquired immune deficiency syndrome; and

(2) circumstances under which exposure to such etiologic agent may occur."

It is further noted that "The Secretary [of Health and Human Services] shall transmit the guidelines issued under subsection (a) to the Secretary of Labor for use by the Secretary of Labor in the development of standards to be issued under the Occupational Safety and Health Act of 1970," and that "the Secretary, acting through the Director of the Centers for Disease Control, shall develop a model curriculum for emergency response employees with respect to the prevention of exposure to the etiologic agent for acquired immune deficiency syndrome during the process of responding to emergencies."

Following development of these guidelines and curriculum, "[t]he Secretary shall –

(A) transmit to State public health officers copies of the guidelines and the model curriculum developed under paragraph (1) with the request that such officers disseminate such copies as appropriate throughout the State; and

(B) make such copies available to the public."

B. Purpose and Organization of Document

The purpose of this document is to provide an overview of the modes of transmission of human immunodeficiency virus (HIV) in the workplace, an assessment of the risk of transmission under various assumptions, principles underlying the control of risk, and specific risk-control recommendations for employers and workers. This document also includes information on medical management of persons who have sustained an exposure at the workplace to these viruses (e.g., an emergency medical technicians who incur a needle-stick injury while performing professional duties). These guidelines are intended for use by a technically informed audience. As noted above, a separate model curriculum based on the principles and practices discussed in this document is being developed for use in training workers and will contain less technical wording.

Information concerning the protection of workers against acquisition of the human immunodeficiency virus (HIV) while performing job duties, the virus that causes AIDS, is presented here. Information on hepatitis B virus (HBV) is also presented in this document on the basis of the following assumptions:

- the modes of transmission for hepatitis B virus (HBV) are similar to those of HIV,
- the potential for HBV transmission in the occupational setting is greater than for HIV,
- there is a larger body of experience relating to controlling transmission of HBV in the workplace, and
- general practices to prevent the transmission of HBV will also minimize the risk of transmission of HIV.

Blood-borne transmission of other pathogens not specifically addressed here will be interrupted by adherence to the precautions noted below. It is important to note that the implementation of control measures for HIV and HBV does not obviate the need for continued adherence to general infection-control principles and general hygiene measures (e.g., hand washing) for preventing transmission of other infectious diseases to both worker and client. General guidelines for control of these diseases have been published (*1,2,3*).

This document was developed primarily to provide guidelines for fire-service personnel, emergency medical technicians, paramedics (see section IV, page 19), and law-enforcement and correctional-facility personnel (see section V, page 22). Throughout the report, paramedics and emergency medical technicians are called "emergency medical workers" and fire-service, law-enforcement, and correctional-facility personnel, "public-safety workers." Previously issued guidelines address the needs of hospital-, laboratory-, and clinic-based health-care workers (*4,5*). A condensation of general guidelines for protection of workers from transmission of blood-borne pathogens, derived from the Joint Advisory Notice of the Departments of Labor and Health and Human Services (*6*), is provided in section III (see page 11).

C. Modes and Risk of Virus Transmission in the Workplace

Although the potential for HBV transmission in the workplace setting is greater than for HIV, the modes of transmission for these two viruses are similar. Both have been transmitted in occupational settings only by percutaneous inoculation or contact with an open wound, nonintact (e.g., chapped, abraded, weeping, or dermatitic) skin, or mucous membranes to blood, blood-contaminated body fluids, or concentrated virus. **Blood is the single most important source of HIV and HBV in the workplace setting.** Protection measures against HIV and HBV for workers should focus primarily on preventing these types of exposures to blood as well as on delivery of HBV vaccination.

The risk of hepatitis B infection following a parenteral (i.e., needle stick or cut) exposure to blood is directly proportional to the probability that the blood contains hepatitis B surface antigen (HBsAg), the immunity status of the recipient, and on the efficiency of transmission (*7*). The probability of the source of the blood being HBsAg positive varies from 1 to 3 per thousand in the general population to 5%–15% in groups at high risk for HBV infection, such as immigrants from areas of high endemicity (China and Southeast Asia, sub-Saharan Africa, most Pacific islands, and the Amazon Basin); clients in institutions for the mentally retarded; intravenous drug users; homosexually active males; and household (sexual and non-sexual) contacts of HBV carriers. Of persons who have not had prior hepatitis B vaccination or postexposure prophylaxis, 6%–30% of persons who receive a needle-stick exposure from an HBsAg-positive individual will become infected (*7*).

The risk of infection with HIV following one needle-stick exposure to blood from a patient known to be infected with HIV is approximately 0.5% (*4,5*). This rate of transmission is considerably lower than that for HBV, probably as a result of the significantly lower concentrations of virus in the blood of HIV-infected persons. Table 1 (see page 31) presents theoretical data concerning the likelihood of infection given repeated needle-stick injuries involving patients whose HIV serostatus is unknown. Though inadequately quantified, the risk from exposure of nonintact skin or mucous membranes is likely to be far less than that from percutaneous inoculation.

D. Transmission of Hepatitis B Virus to Workers

1. Health-care workers

In 1987, the CDC estimated the total number of HBV infections in the United States to be 300,000 per year, with approximately 75,000 (25%) of infected persons developing acute hepatitis. Of these infected individuals, 18,000–30,000 (6%–10%) will become HBV carriers, at risk of developing chronic liver disease (chronic active hepatitis, cirrhosis, and primary liver cancer), and infectious to others.

CDC has estimated that 12,000 health-care workers whose jobs entail exposure to blood become infected with HBV each year, that 500–600 of them are hospitalized as a result of that infection, and that 700–1,200 of those infected become HBV carriers. Of the infected workers, approximately 250 will die (12–15 from fulminant hepatitis, 170–200 from cirrhosis, and 40–50 from liver cancer). Studies indicate that

10%–30% of health-care or dental workers show serologic evidence of past or present HBV infection.

2. Emergency medical and public-safety workers

Emergency medical workers have an increased risk for hepatitis B infection (*8,9,10*). The degree of risk correlates with the frequency and extent of blood exposure during the conduct of work activities. A few studies are available concerning risk of HBV infection for other groups of public-safety workers (law-enforcement personnel and correctional-facility workers), but reports that have been published do not document any increased risk for HBV infection (*11,12,13*). Nevertheless, in occupational settings in which workers may be routinely exposed to blood or other body fluids as described below, an increased risk for occupational acquisition of HBV infection must be assumed to be present.

3. Vaccination for hepatitis B virus

A safe and effective vaccine to prevent hepatitis B has been available since 1982. Vaccination has been recommended for health-care workers regularly exposed to blood and other body fluids potentially contaminated with HBV (*7,14,15*). In 1987, the Department of Health and Human Services and the Department of Labor stated that hepatitis B vaccine should be provided to all such workers at no charge to the worker (*6*).

Available vaccines stimulate active immunity against HBV infection and provide over 90% protection against hepatitis B for 7 or more years following vaccination (*7*). Hepatitis B vaccines also are 70–88% effective when given within 1 week after HBV exposure. Hepatitis B immune globulin (HBIG), a preparation of immunoglobulin with high levels of antibody to HBV (anti-HBs), provides temporary passive protection following exposure to HBV. Combination treatment with hepatitis B vaccine and HBIG is over 90% effective in preventing hepatitis B following a documented exposure (*7*).

E. Transmission of Human Immunodeficiency Virus to Workers

1. Health-care workers with AIDS

As of September 19, 1988, a total of 3,182 (5.1%) of 61,929 adults with AIDS, who had been reported to the CDC national surveillance system and for whom occupational information was available, reported being employed in a health-care setting. Of the health-care workers with AIDS, 95% reported high-risk behavior; for the remaining 5% (169 workers), the means of HIV acquisition was undetermined.

Of these 169 health-care workers with AIDS with undetermined risk, information is incomplete for 28 (17%) because of death or refusal to be interviewed; 97 (57%) are still being investigated. The remaining 44 (26%) health-care workers were interviewed directly or had other follow-up information available. The occupations of these 44 were nine nursing assistants (20%); eight physicians (18%), four of whom were surgeons; eight housekeeping or maintenance workers (18%); six nurses (14%); four clinical laboratory technicians (9%); two respiratory therapists (5%); one dentist (2%); one paramedic (2%); one embalmer (2%); and four others who did not have contact with patients (9%). Eighteen of these 44 health-care workers reported parenteral and/or other non-needle-stick exposure to blood or other body fluids from patients in the 10 years preceding their diagnosis of AIDS. None of these exposures involved a patient with AIDS or known HIV infection, and HIV seroconversion of the health-care worker was not documented following a specific exposure.

2. Human immunodeficiency virus transmission in the workplace

As of July 31, 1988, 1,201 health-care workers had been enrolled and tested for HIV antibody in ongoing CDC surveillance of health-care workers exposed via needlestick or splashes to skin or mucous membranes to blood from patients known to be HIV-infected (*16*). Of 860 workers who had received needle-stick injuries or cuts with sharp objects (i.e., parenteral exposures) and whose serum had been tested for HIV antibody at least 180 days after exposure, 4 were positive, yielding a seroprevalence rate of 0.47%. Three of these individuals experienced an acute retroviral syndrome associated with documented seroconversion. Investigation revealed no nonoccupational risk factors for these three workers. Serum collected within 30 days of exposure was not available from the fourth person. This worker had an HIV-seropositive sexual partner, and heterosexual acquisition of infection cannot be excluded. None of the 103 workers who had contamination of mucous membranes or nonintact skin and whose serum had been tested at least 180 days after exposure developed serologic evidence of HIV infection.

Two other ongoing prospective studies assess the risk of nosocomial acquisition of HIV infection among health-care workers in the United States. As of April 1988, the National Institutes of Health had tested 983 health-care workers, 137 with documented needle-stick injuries and 345 health-care workers who had sustained mucous-membrane exposures to blood or other body fluids of HIV-infected patients; none had seroconverted (*17*) (one health-care worker who subsequently experienced an occupational HIV seroconversion has since been reported from NIH [*18*]). As of March 15, 1988, a similar study at the University of California of 212 health-care workers with 625 documented accidental parenteral exposures involving HIV-infected patients had identified one seroconversion following a needle stick (*19*). Prospective studies in the United Kingdom and Canada show no evidence of HIV transmission among 220 health-care workers with parenteral, mucous-membrane, or cutaneous exposures (*20,21*).

In addition to the health-care workers enrolled in these longitudinal surveillance studies, case histories have been published in the scientific literature for 19 HIV-infected health-care workers (13 with documented seroconversion and 6 without documented seroconversion). None of these workers reported nonoccupational risk factors (see Table 2, pages 32, 33).

3. Emergency medical service and public-safety workers

In addition to the one paramedic with undetermined risk discussed above, three public-safety workers (law-enforcement officers) are classified in the undetermined risk group. Follow-up investigations of these workers could not determine conclusively if HIV infection was acquired during the performance of job duties.

II. Principles of Infection Control and Their Application to Emergency and Public-Safety Workers

A. General Infection Control

Within the health-care setting, general infection control procedures have been developed to minimize the risk of patient acquisition of infection from contact with contaminated devices, objects, or surfaces or of transmission of an infectious agent from health-care workers to patients (*1,2,3*). Such procedures also protect workers from the risk of becoming infected. General infection-control procedures are designed to prevent transmission of a wide range of microbiological agents and to provide a wide margin of safety in the varied situations encountered in the health-care environment.

General infection-control principles are applicable to other work environments where workers contact other individuals and where transmission of infectious agents may occur. The modes of transmission noted in the hospital and medical office environment are observed in the work situations of emergency and public-safety workers, as well. Therefore, the principles of infection control developed for hospital and other health-care settings are also applicable to these work situations. Use of general infection control measures, as adapted to the work environments of emergency and public-safety workers, is important to protect both workers and individuals with whom they work from a variety of infectious agents, not just HIV and HBV.

Because emergency and public-safety workers work in environments that provide inherently unpredictable risks of exposures, general infection-control procedures should be adapted to these work situations. Exposures are unpredictable, and protective measures may often be used in situations that do not appear to present risk. Emergency and public-safety workers perform their duties in the community under extremely variable conditions; thus, control measures that are simple and uniform across all situations have the greatest likelihood of worker compliance. Administrative procedures to ensure compliance also can be more readily developed than when procedures are complex and highly variable.

B. Universal Blood and Body Fluid Precautions to Prevent Occupational HIV and HBV Transmission

In 1985, CDC developed the strategy of "universal blood and body fluid precautions" to address concerns regarding transmission of HIV in the health-care setting (*4*). The concept, now referred to simply as "universal precautions" stresses that all patients should be assumed to be infectious for HIV and other blood-borne pathogens. In the hospital and other health-care setting, "universal precautions" should be followed when workers are exposed to blood, certain other body fluids (amniotic fluid, pericardial fluid, peritoneal fluid, pleural fluid, synovial fluid, cerebrospinal fluid, semen, and vaginal secretions), or any body fluid visibly contaminated with blood. Since HIV and HBV transmission has not been documented from exposure to other body fluids (feces, nasal secretions, sputum, sweat, tears, urine, and vomitus), "universal precautions" do not apply to these fluids. Universal precautions also do not apply to saliva, except in the dental setting, where saliva is likely to be contaminated with blood (*7*).

For the purpose of this document, human "exposure" is defined as contact with blood or other body fluids to which universal precautions apply through percutaneous inoculation or contact with an open wound, nonintact skin, or mucous membrane during the performance of normal job duties. An "exposed worker" is defined, for the purposes of this document, as an individual exposed, as described above, while performing normal job duties.

The unpredictable and emergent nature of exposures encountered by emergency and public-safety workers may make differentiation between hazardous body fluids and those which are not hazardous very difficult and often impossible. For example, poor lighting may limit the worker's ability to detect visible blood in vomitus or feces. Therefore, when emergency medical and public-safety workers encounter body fluids under uncontrolled, emergency circumstances in which differentiation between fluid types is difficult, if not impossible, they should treat all body fluids as potentially hazardous.

The application of the principles of universal precautions to the situations encountered by these workers results in the development of guidelines (listed below) for work practices, use of personal protective equipment, and other protective measures. To minimize the risks of acquiring HIV and HBV during performance of job duties, emergency and public-safety workers should be protected from exposure to blood and other body fluids as circumstances dictate. Protection can be achieved through adherence to work practices designed to minimize or eliminate exposure and through use of personal protective equipment (i.e., gloves, masks, and protective clothing), which provide a barrier between the worker and the exposure source. In some situations, redesign of selected aspects of the job through equipment modifications or environmental control can further reduce risk. These approaches to primary prevention should be used together to achieve maximal reduction of the risk of exposure.

If exposure of an individual worker occurs, medical management, consisting of collection of pertinent medical and occupational history, provision of treatment, and counseling regarding future work and personal behaviors, may reduce risk of developing disease as a result of the exposure episode (*22*). Following episodic (or continuous) exposure, decontamination and disinfection of the work environment, devices, equipment, and clothing or other forms of personal protective equipment can reduce subsequent risk of exposures. Proper disposal of contaminated waste has similar benefits.

III. Employer Responsibilities

A. General

Detailed recommendations for employer responsibilities in protecting workers from acquisition of blood-borne diseases in the workplace have been published in the Department of Labor and Department of Health and Human Services Joint Advisory Notice and are summarized here (*6*). In developing programs to protect workers, employers should follow a series of steps: 1) classification of work activity, 2) development of standard operating procedures, 3) provision of training and education, 4) development of procedures to ensure and monitor compliance, and 5) workplace redesign. As a first step, every employer should classify work activities into one of three categories of potential exposure (see Table 3, page 34). Employers should make protective equipment available to all workers when they are engaged in Category I or II activities. Employers should ensure that the appropriate protective equipment is used by workers when they perform Category I activities.

As a second step, employers should establish a detailed work practices program that includes standard operating procedures (SOPs) for all activities having the potential for exposure. Once these SOPs are developed, an initial and periodic worker education program to assure familiarity with work practices should be provided to potentially exposed workers. No worker should engage in such tasks or activities before receiving training pertaining to the SOPs, work practices, and protective equipment required for that task. Examples of personal protective equipment for the prehospital setting (defined as a setting where delivery of emergency health care takes place away from a hospital or other health-care setting) are provided in Table 4 (page 35). (A curriculum for such training programs is being developed in conjunction with these guidelines and should be consulted for further information concerning such training programs.)

To facilitate and monitor compliance with SOPs, administrative procedures should be developed and records kept as described in the Joint Advisory Notice (*6*). Employers should monitor the workplace to ensure that required work practices are observed and that protective clothing and equipment are provided and properly used. The employer should maintain records documenting the administrative procedures used to classify job activities and copies of all SOPs for tasks or activities involving predictable or unpredictable exposure to blood or other body fluids to which universal precautions apply. In addition, training records, indicating the dates of training sessions, the content of those training sessions along with the names of all persons conducting the training, and the names of all those receiving training should also be maintained.

Whenever possible, the employer should identify devices and other approaches to modifying the work environment which will reduce exposure risk. Such approaches are desirable, since they don't require individual worker action or management activity. For example, jails and correctional facilities should have classification procedures that require the segregation of offenders who indicate through their actions or words that they intend to attack correctional-facility staff with the intent of transmitting HIV or HBV.

B. Medical

In addition to the general responsibilities noted above, the employer has the specific responsibility to make available to the worker a program of medical management. This program is designed to provide for the reduction of risk of infection by HBV and for counseling workers concerning issues regarding HIV and HBV. These services should be provided by a licensed health professional. All phases of medical management and counseling should ensure that the confidentiality of the worker's and client's medical data is protected.

1. Hepatitis B vaccination

All workers whose jobs involve participation in tasks or activities with exposure to blood or other body fluids to which universal precautions apply (as defined above on page 9) should be vaccinated with hepatitis B vaccine.

2. Management of percutaneous exposure to blood and other infectious body fluids

Once an exposure has occurred (as defined above on page 10), a blood sample should be drawn after consent is obtained from the individual from whom exposure occurred and tested for hepatitis B surface antigen (HBsAg) and antibody to human immunodeficiency virus (HIV antibody). Local laws regarding consent for testing source individuals should be followed. Policies should be available for testing source individuals in situations where consent cannot be obtained (e.g., an unconscious patient). Testing of the source individual should be done at a location where appropriate pretest counseling is available; posttest counseling and referral for treatment should be provided. It is extremely important that all individuals who seek consultation for any HIV-related concerns receive counseling as outlined in the "Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS" (*22*).

a. Hepatitis B virus postexposure management

For an exposure to a source individual found to be positive for HBsAg, the worker who has not previously been given hepatitis B vaccine should receive the vaccine series. A single dose of hepatitis B immune globulin (HBIG) is also recommended, if this can be given within 7 days of exposure. For exposures from an HBsAg-positive source to workers who have previously received vaccine, the exposed worker should be tested for antibody to hepatitis B surface antigen (anti-HBs), and given one dose of vaccine and one dose of HBIG if the antibody level in the worker's blood sample is inadequate (i.e., < 10 SRU by RIA, negative by EIA) (*7*).

If the source individual is negative for HBsAg and the worker has not been vaccinated, this opportunity should be taken to provide hepatitis B vaccination.

If the source individual refuses testing or he/she cannot be identified, the unvaccinated worker should receive the hepatitis B vaccine series. HBIG administration should be considered on an individual basis when the source individual is known or suspected to be at high risk of HBV infection. Management and treatment, if any, of previously vaccinated workers who receive an exposure from a source who refuses testing or is not identifiable should be individualized (*7*).

b. Human immunodeficiency virus postexposure management

For any exposure to a source individual who has AIDS, who is found to be positive for HIV infection (*4*), or who refuses testing, the worker should be counseled regarding the risk of infection and evaluated clinically and serologically for evidence of HIV infection as soon as possible after the exposure. In view of the evolving nature of HIV postexposure management, the health-care provider should be well informed of current PHS guidelines on this subject. The worker should be advised to report and seek medical evaluation for any acute febrile illness that occurs within 12 weeks after the exposure. Such an illness, particularly one characterized by fever, rash, or lymphadenopathy, may be indicative of recent HIV infection. Following the initial test at the time of exposure, seronegative workers should be retested 6 weeks, 12 weeks, and 6 months after exposure to determine whether transmission has occurred. During this follow-up period (especially the first 6-12 weeks after exposure, when most infected persons are expected to seroconvert), exposed workers should follow U.S. Public Health Service (PHS) recommendations for preventing transmission of HIV (*22*). These include refraining from blood donation and using appropriate protection during sexual intercourse (*23*). During all phases of follow-up, it is vital that worker confidentiality be protected.

If the source individual was tested and found to be seronegative, baseline testing of the exposed worker with follow-up testing 12 weeks later may be performed if desired by the worker or recommended by the health-care provider.

If the source individual cannot be identified, decisions regarding appropriate follow-up should be individualized. Serologic testing should be made available by the employer to all workers who may be concerned they have been infected with HIV through an occupational exposure as defined above (see page 10).

3. Management of human bites

On occasion, police and correctional-facility officers are intentionally bitten by suspects or prisoners. When such bites occur, routine medical and surgical therapy (including an assessment of tetanus vaccination status) should be implemented as soon as possible, since such bites frequently result in infection with organisms other than HIV and HBV. Victims of bites should be evaluated as described above (see page 12) for exposure to blood or other infectious body fluids.

Saliva of some persons infected with HBV has been shown to contain HBV-DNA at concentrations 1/1,000 to 1/10,000 of that found in the infected person's serum (*5,24*). HbsAg-positive saliva has been shown to be infectious when injected into experimental animals and in human bite exposures (*25–27*). However, HBsAg-positive saliva has not been shown to be infectious when applied to oral mucous membranes in experimental primate studies (*27*) or through contamination of musical instruments or cardiopulmonary resuscitation dummies used by HBV carriers (*28,29*). Epidemiologic studies of nonsexual household contacts of HIV-infected patients, including several small series in which HIV transmission failed to occur after bites or after percutaneous inoculation or contamination of cuts and open wounds with saliva from HIV-infected patients, suggest that the potential for salivary transmission of HIV is remote (*5,30–33*). One case report from Germany has suggested the possibility of transmission of HIV in a household setting from an infected child to a sibling through a human bite (*34*). The bite did not break the skin or result in bleeding. Since the date of seroconversion to HIV was not known for either child in this case, evidence for the role of saliva in the transmission of virus is unclear (*34*).)

4. Documentation of exposure and reporting

As part of the confidential medical record, the circumstances of exposure should be recorded. Relevant information includes the activity in which the worker was engaged at the time of exposure, the extent to which appropriate work practices and protective equipment were used, and a description of the source of exposure.

Employers have a responsibility under various federal and state laws and regulations to report occupational illnesses and injuries. Existing programs in the National Institute for Occupational Safety and Health (NIOSH), Department of Health and Human Services; the Bureau of Labor Statistics, Department of Labor (DOL); and the Occupational Safety and Health Administration (DOL) receive such information for the purposes of surveillance and other objectives. Cases of infectious disease, including AIDS and HBV infection, are reported to the Centers for Disease Control through State health departments.

5. Management of HBV- or HIV-infected workers

Transmission of HBV from health-care workers to patients has been documented. Such transmission has occurred during certain types of invasive procedures (e.g., oral and gynecologic surgery) in which health-care workers, when tested, had very high concentrations of HBV in their blood (at least 100 million infectious virus particles per milliliter, a concentration much higher than occurs with HIV infection), and the health-care workers sustained a puncture wound while performing invasive procedures or had exudative or weeping lesions or microlacerations that allowed virus to contaminate instruments or open wounds of patients (*35,36*). A worker who is HBsAg positive and who has transmitted hepatitis B virus to another individual during the performance of his or her job duties should be excluded from the performance of those job duties which place other individuals at risk for acquisition of hepatitis B infection.

Workers with impaired immune systems resulting from HIV infection or other causes are at increased risk of acquiring or experiencing serious complications of infectious disease. Of particular concern is the risk of severe infection following exposure to other persons with infectious diseases that are easily transmitted if appropriate precautions are not taken (e.g., measles, varicella). Any worker with an impaired immune system should be counseled about the potential risk associated with providing health care to persons with any transmissible infection and should continue to follow existing recommendations for infection control to minimize risk of exposure to other infectious agents (*2,3*). Recommendations of the Immunization Practices Advisory Committee (ACIP) and institutional policies concerning requirements for vaccinating workers with live-virus vaccines (e.g., measles, rubella) should also be considered.

The question of whether workers infected with HIV can adequately and safely be allowed to perform patient-care duties or whether their work assignments should be changed must be determined on an individual basis. These decisions should be made by the worker's personal physician(s) in conjunction with the employer's medical advisors.

C. Disinfection, Decontamination, and Disposal

As described in Section I.C. (see page 4), the only documented occupational risks of HIV and HBV infection are associated with parenteral (including open wound) and mucous membrane exposure to blood and other potentially infectious body fluids. Nevertheless, the precautions described below should be routinely followed.

1. Needle and sharps disposal

All workers should take precautions to prevent injuries caused by needles, scalpel blades, and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments after procedures. To prevent needle-stick injuries, needles should not be recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. After they are used, disposable syringes and needles, scalpel blades, and other sharp items should be placed in puncture-resistant containers for disposal; the puncture-resistant containers should be located as close as practical to the use area (e.g., in the ambulance or, if sharps are carried to the scene of victim assistance from the ambulance, a small puncture-resistant container should be carried to the scene, as well). Reusable needles should be left on the syringe body and should be placed in a puncture-resistant container for transport to the reprocessing area.

2. Hand washing

Hands and other skin surfaces should be washed immediately and thoroughly if contaminated with blood, other body fluids to which universal precautions apply, or potentially contaminated articles. Hands should always be washed after gloves are removed, even if the gloves appear to be intact. Hand washing should be completed using the appropriate facilities, such as utility or restroom sinks. Waterless antiseptic hand cleanser should be provided on responding units to use when hand-washing facilities are not available. When hand-washing facilities are available, wash hands with warm water and soap. When hand-washing facilities are not available, use a waterless antiseptic hand cleanser. The manufacturer's recommendations for the product should be followed.

3. Cleaning, disinfecting, and sterilizing

Table 5 (see pages 36, 37) presents the methods and applications for cleaning, disinfecting, and sterilizing equipment and surfaces in the prehospital setting. These methods also apply to housekeeping and other cleaning tasks. Previously issued guidelines for health-care workers contain more detailed descriptions (*4*).

4. Cleaning and decontaminating spills of blood

All spills of blood and blood-contaminated fluids should be promptly cleaned up using an EPA-approved germicide or a 1:100 solution of household bleach in the following manner while wearing gloves. Visible material should first be removed with disposable towels or other appropriate means that will ensure against direct contact with blood. If splashing is anticipated, protective eyewear should be worn along with an impervious gown or apron which provides an effective barrier to splashes. The area should then be decontaminated with an appropriate germicide. Hands should be washed following removal of gloves. Soiled cleaning equipment should be cleaned and decontaminated or placed in an appropriate container and disposed of according to agency policy. Plastic bags should be available for removal of contaminated items from the site of the spill.

Shoes and boots can become contaminated with blood in certain instances. Where there is massive blood contamination on floors, the use of disposable impervious shoe coverings should be considered. Protective gloves should be worn to remove contaminated shoe coverings. The coverings and gloves should be disposed of in plastic bags. A plastic bag should be included in the crime scene kit or the car which is to be used for the disposal of contaminated items. Extra plastic bags should be stored in the police cruiser or emergency vehicle.

5. Laundry

Although soiled linen may be contaminated with pathogenic microorganisms, the risk of actual disease transmission is negligible. Rather than rigid procedures and specifications, hygienic storage and processing of clean and soiled linen are recommended. Laundry facilities and/or services should be made routinely available by the employer. Soiled linen should be handled as little as possible and with minimum agitation to prevent gross microbial contamination of the air and of persons handling the linen. All soiled linen should be bagged at the location where it was used. Linen soiled with blood should be placed and transported in bags that prevent leakage. Normal laundry cycles should be used according to the washer and detergent manufacturers' recommendations.

6. Decontamination and laundering of protective clothing

Protective work clothing contaminated with blood or other body fluids to which universal precautions apply should be placed and transported in bags or containers that prevent leakage. Personnel involved in the bagging, transport, and laundering of contaminated clothing should wear gloves. Protective clothing and station and work uniforms should be washed and dried according to the manufacturer's instructions. Boots and leather goods may be brush-scrubbed with soap and hot water to remove contamination.

7. Infective waste

The selection of procedures for disposal of infective waste is determined by the relative risk of disease transmission and application of local regulations, which vary widely. **In all cases, local regulations should be consulted prior to disposal procedures and followed.** Infective waste, in general, should either be incinerated or should be decontaminated before disposal in a sanitary landfill. Bulk blood, suctioned fluids, excretions, and secretions may be carefully poured down a drain connected to a sanitary sewer, where permitted. Sanitary sewers may also be used to dispose of other infectious wastes capable of being ground and flushed into the sewer, where permitted. Sharp items should be placed in puncture-proof containers and other blood-contaminated items should be placed in leak-proof plastic bags for transport to an appropriate disposal location.

Prior to the removal of protective equipment, personnel remaining on the scene after the patient has been cared for should carefully search for and remove contaminated materials. Debris should be disposed of as noted above.

IV. Fire and Emergency Medical Services

The guidelines that appear in this section apply to fire and emergency medical services. This includes structural fire fighters, paramedics, emergency medical technicians, and advanced life support personnel. Fire fighters often provide emergency medical services and therefore encounter the exposures common to paramedics and emergency medical technicians. Job duties are often performed in uncontrolled environments, which, due to a lack of time and other factors, do not allow for application of a complex decision-making process to the emergency at hand.

The general principles presented here have been developed from existing principles of occupational safety and health in conjunction with data from studies of health-care workers in hospital settings. The basic premise is that workers must be protected from exposure to blood and other potentially infectious body fluids in the course of their work activities. There is a paucity of data concerning the risks these worker groups face, however, which complicates development of control principles. Thus, the guidelines presented below are based on principles of prudent public health practice.

Fire and emergency medical service personnel are engaged in delivery of medical care in the prehospital setting. The following guidelines are intended to assist these personnel in making decisions concerning use of personal protective equipment and resuscitation equipment, as well as for decontamination, disinfection, and disposal procedures.

A. Personal Protective Equipment

Appropriate personal protective equipment should be made available routinely by the employer to reduce the risk of exposure as defined above. For many situations, the chance that the rescuer will be exposed to blood and other body fluids to which universal precautions apply can be determined in advance. Therefore, if the chances of being exposed to blood is high (e.g., CPR, IV insertion, trauma, delivering babies), the worker should put on protective attire before beginning patient care. Table 4 (see page 35) sets forth examples of recommendations for personal protective equipment in the prehospital setting; the list is not intended to be all-inclusive.

1. Gloves

Disposable gloves should be a standard component of emergency response equipment, and should be donned by all personnel prior to initiating any emergency patient care tasks involving exposure to blood or other body fluids to which universal precautions apply. Extra pairs should always be available. Considerations in the choice of disposable gloves should include dexterity, durability, fit, and the task being performed. Thus, there is no single type or thickness of glove appropriate for protection in all situations. For situations where large amounts of blood are likely to be encountered, it is important that gloves fit tightly at the wrist to prevent blood contamination of hands around the cuff. For multiple trauma victims, gloves should be changed between patient contacts, if the emergency situation allows.

Greater personal protective equipment measures are indicated for situations where broken glass and sharp edges are likely to be encountered, such as extricating a person from an automobile wreck. Structural fire-fighting gloves that meet the Federal OSHA requirements for fire-fighters gloves (as contained in 29 CFR 1910.156 or National Fire Protection Association Standard 1973, Gloves for Structural Fire Fighters) should be worn in any situation where sharp or rough surfaces are likely to be encountered (*37*).

While wearing gloves, avoid handling personal items, such as combs and pens, that could become soiled or contaminated. Gloves that have become contaminated with blood or other body fluids to which universal precautions apply should be removed as soon as possible, taking care to avoid skin contact with the exterior surface. Contaminated gloves should be placed and transported in bags that prevent leakage and should be disposed of or, in the case of reusable gloves, cleaned and disinfected properly.

2. Masks, eyewear, and gowns

Masks, eyewear, and gowns should be present on all emergency vehicles that respond or potentially respond to medical emergencies or victim rescues. These protective barriers should be used in accordance with the level of exposure encountered. Minor lacerations or small amounts of blood do not merit the same extent of barrier use as required for exsanguinating victims or massive arterial bleeding. Management of the patient who is not bleeding, and who has no bloody body fluids present, should not routinely require use of barrier precautions. Masks and eyewear (e.g., safety glasses) should be worn together, or a faceshield should be used by all personnel prior to any situation where splashes of blood or other body fluids to which universal precautions apply are likely to occur. Gowns or aprons should be worn to protect clothing from splashes with blood. If large splashes or quantities of blood are present or anticipated, impervious gowns or aprons should be worn. An extra change of work clothing should be available at all times.

3. Resuscitation equipment

No transmission of HBV or HIV infection during mouth-to-mouth resuscitation has been documented. However, because of the risk of salivary transmission of other infectious diseases (e.g., herpes simplex and *Neisseria meningitidis*) and the theoretical risk of HIV and HBV transmission during artificial ventilation of trauma victims, disposable airway equipment or resuscitation bags should be used. Disposable resuscitation equipment and devices should be used once and disposed of or, if reusable, thoroughly cleaned and disinfected after each use according to the manufacturer's recommendations.

Mechanical respiratory assist devices (e.g., bag-valve masks, oxygen demand valve resuscitators) should be available on all emergency vehicles and to all emergency response personnel that respond or potentially respond to medical emergencies or victim rescues.

Pocket mouth-to-mouth resuscitation masks designed to isolate emergency response personnel (i.e., double lumen systems) from contact with victims' blood and blood-contaminated saliva, respiratory secretions, and vomitus should be provided to all personnel who provide or potentially provide emergency treatment.

V. Law-Enforcement and Correctional-Facility Officers

Law-enforcement and correctional-facility officers may face the risk of exposure to blood during the conduct of their duties. For example, at the crime scene or during processing of suspects, law-enforcement officers may encounter blood-contaminated hypodermic needles or weapons, or be called upon to assist with body removal. Correctional-facility officers may similarly be required to search prisoners or their cells for hypodermic needles or weapons, or subdue violent and combative inmates.

The following section presents information for reducing the risk of acquiring HIV and HBV infection by law-enforcement and correctional-facility officers as a consequence of carrying out their duties. However, there is an extremely diverse range of potential situations which may occur in the control of persons with unpredictable, violent, or psychotic behavior. Therefore, informed judgment of the individual officer is paramount when unusual circumstances or events arise. These recommendations should serve as an adjunct to rational decision making in those situations where specific guidelines do not exist, particularly where immediate action is required to preserve life or prevent significant injury.

The following guidelines are arranged into three sections: a section addressing concerns shared by both law-enforcement and correctional-facility officers, and two sections dealing separately with law-enforcement officers and correctional-facility officers, respectively. Table 4 (see page 35) contains selected examples of personal protective equipment that may be employed by law-enforcement and correctional-facility officers.

A. Law-Enforcement and Correctional-Facilities Considerations

1. Fights and assaults

Law-enforcement and correctional-facility officers are exposed to a range of assaultive and disruptive behavior through which they may potentially become exposed to blood or other body fluids containing blood. Behaviors of particular concern are biting, attacks resulting in blood exposure, and attacks with sharp objects. Such behaviors may occur in a range of law-enforcement situations including arrests, routine interrogations, domestic disputes, and lockup operations, as well as in correctional-facility activities. Hand-to-hand combat may result in bleeding and may thus incur a greater chance for blood-to-blood exposure, which increases the chances for blood-borne disease transmission.

Whenever the possibility for exposure to blood or blood-contaminated body fluids exists, the appropriate protection should be worn, if feasible under the circumstances. In all cases, extreme caution must be used in dealing with the suspect or prisoner if there is any indication of assaultive or combative behavior. When blood is present and a suspect or an inmate is combative or threatening to staff, gloves should always be put on as soon as conditions permit. In case of blood contamination of clothing, an extra change of clothing should be available at all times.

2. Cardiopulmonary resuscitation

Law-enforcement and correctional personnel are also concerned about infection with HIV and HBV through administration of cardiopulmonary resuscitation (CPR). Although there have been no documented cases of HIV transmission through this mechanism, the possibility of transmission of other infectious diseases exists. Therefore, agencies should make protective masks or airways available to officers and provide training in their proper use. Devices with one-way valves to prevent the patients' saliva or vomitus from entering the caregiver's mouth are preferable.

B. Law-Enforcement Considerations

1. Searches and evidence handling

Criminal justice personnel have potential risks of acquiring HBV or HIV infection through exposures which occur during searches and evidence handling. Penetrating injuries are known to occur, and puncture wounds or needle sticks in particular pose a hazard during searches of persons, vehicles, or cells, and during evidence handling. The following precautionary measures will help to reduce the risk of infection:

- An officer should use great caution in searching the clothing of suspects. Individual discretion, based on the circumstances at hand, should determine if a suspect or prisoner should empty his own pockets or if the officer should use his own skills in determining the contents of a suspect's clothing.

- A safe distance should always be maintained between the officer and the suspect.

- Wear protective gloves if exposure to blood is likely to be encountered.

- Wear protective gloves for all body cavity searches.

- If cotton gloves are to be worn when working with evidence of potential latent fingerprint value at the crime scene, they can be worn over protective disposable gloves when exposure to blood may occur.

- Always carry a flashlight, even during daylight shifts, to search hidden areas. Whenever possible, use long-handled mirrors and flashlights to search such areas (e.g., under car seats).

- If searching a purse, carefully empty contents directly from purse, by turning it upside down over a table.

- Use puncture-proof containers to store sharp instruments and clearly marked plastic bags to store other possibly contaminated items.

- To avoid tearing gloves, use evidence tape instead of metal staples to seal evidence.

- Local procedures for evidence handling should be followed. In general, items should be air dried before sealing in plastic.

Not all types of gloves are suitable for conducting searches. Vinyl or latex rubber gloves provide little protection against sharp instruments, and they are not puncture-proof. There is a direct trade-off between level of protection and manipulability. In other words, the thicker the gloves, the more protection they provide, but the less effective they are in locating objects. Thus, there is no single type or thickness of glove appropriate for protection in all situations. Officers should select the type and thickness of glove which provides the best balance of protection and search efficiency.

Officers and crime scene technicians may confront unusual hazards, especially when the crime scene involves violent behavior, such as a homicide where large amounts of blood are present. Protective gloves should be available and worn in this setting. In addition, for very large spills, consideration should be given to other protective clothing, such as overalls, aprons, boots, or protective shoe covers. They should be changed if torn or soiled, and always removed prior to leaving the scene. While wearing gloves, avoid handling personal items, such as combs and pens, that could become soiled or contaminated.

Face masks and eye protection or a face shield are required for laboratory and evidence technicians whose jobs which entail potential exposures to blood via a splash to the face, mouth, nose, or eyes.

Airborne particles of dried blood may be generated when a stain is scraped. It is recommended that protective masks and eyewear or face shields be worn by laboratory or evidence technicians when removing the blood stain for laboratory analyses.

While processing the crime scene, personnel should be alert for the presence of sharp objects such as hypodermic needles, knives, razors, broken glass, nails, or other sharp objects.

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2. Handling deceased persons and body removal

For detectives, investigators, evidence technicians, and others who may have to touch or remove a body, the response should be the same as for situations requiring CPR or first aid: wear gloves and cover all cuts and abrasions to create a barrier and carefully wash all exposed areas after any contact with blood. The precautions to be used with blood and deceased persons should also be used when handling amputated limbs, hands, or other body parts. Such procedures should be followed after contact with the blood of **anyone**, regardless of whether they are known or suspected to be infected with HIV or HBV.

3. Autopsies

Protective masks and eyewear (or face shields), laboratory coats, gloves, and waterproof aprons should be worn when performing or attending all autopsies. All autopsy material should be considered infectious for both HIV and HBV. Onlookers with an opportunity for exposure to blood splashes should be similarly protected. Instruments and surfaces contaminated during postmortem procedures should be decontaminated with an appropriate chemical germicide (*4*). Many laboratories have more detailed standard operating procedures for conducting autopsies; where available, these should be followed. More detailed recommendations for health-care workers in this setting have been published (*4*).

4. Forensic laboratories

Blood from all individuals should be considered infective. To supplement other worksite precautions, the following precautions are recommended for workers in forensic laboratories.

a. All specimens of blood should be put in a well-constructed, appropriately labelled container with a secure lid to prevent leaking during transport. Care should be taken when collecting each specimen to avoid contaminating the outside of the container and of the laboratory form accompanying the specimen.

b. All persons processing blood specimens should wear gloves. Masks and protective eyewear or face shields should be worn if mucous-membrane contact with blood is anticipated (e.g., removing tops from vacuum tubes). Hands should be washed after completion of specimen processing.

c. For routine procedures, such as histologic and pathologic studies or microbiological culturing, a biological safety cabinet is not necessary. However, biological safety cabinets (Class I or II) should be used whenever procedures are conducted that have a high potential for generating droplets. These include activities such as blending, sonicating, and vigorous mixing.

d. Mechanical pipetting devices should be used for manipulating all liquids in the laboratory. Mouth pipetting must not be done.

e. Use of needles and syringes should be limited to situations in which there is no alternative, and the recommendations for preventing injuries with needles outlined under universal precautions should be followed.

f. Laboratory work surfaces should be cleaned of visible materials and then decontaminated with an appropriate chemical germicide after a spill of blood, semen, or blood-contaminated body fluid and when work activities are completed.

g. Contaminated materials used in laboratory tests should be decontaminated before reprocessing or be placed in bags and disposed of in accordance with institutional and local regulatory policies for disposal of infective waste.

h. Scientific equipment that has been contaminated with blood should be cleaned and then decontaminated before being repaired in the laboratory or transported to the manufacturer.

i. All persons should wash their hands after completing laboratory activities and should remove protective clothing before leaving the laboratory.

j. Area posting of warning signs should be considered to remind employees of continuing hazard of infectious disease transmission in the laboratory setting.

C. Correctional-Facility Considerations

1. Searches

Penetrating injuries are known to occur in the correctional-facility setting, and puncture wounds or needle sticks in particular pose a hazard during searches of prisoners or their cells. The following precautionary measures will help to reduce the risk of infection:

- A correctional-facility officer should use great caution in searching the clothing of prisoners. Individual discretion, based on the circumstances at hand, should determine if a prisoner should empty his own pockets or if the officer should use his own skills in determining the contents of a prisoner's clothing.
- A safe distance should always be maintained between the officer and the prisoner.

- Always carry a flashlight, even during daylight shifts, to search hidden areas. Whenever possible, use long-handled mirrors and flashlights to search such areas (e.g., under commodes, bunks, and in vents in jail cells).

- Wear protective gloves if exposure to blood is likely to be encountered.

- Wear protective gloves for all body cavity searches.

Not all types of gloves are suitable for conducting searches. Vinyl or latex rubber gloves can provide little, if any, protection against sharp instruments, and they are not puncture-proof. There is a direct trade-off between level of protection and manipulability. In other words, the thicker the gloves, the more protection they provide, but the less effective they are in locating objects. Thus, there is no single type or thickness of glove appropriate for protection in all situations. Officers should select the type and thickness of glove which provides the best balance of protection and search efficiency.

2. Decontamination and disposal

Prisoners may spit at officers and throw feces; sometimes these substances have been purposefully contaminated with blood. Although there are no documented cases of HIV or HBV transmission in this manner and transmission by this route would not be expected to occur, other diseases could be transmitted. These materials should be removed with a paper towel after donning gloves, and the area then decontaminated with an appropriate germicide. Following clean-up, soiled towels and gloves should be disposed of properly.

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VII. Tables

Table 1. The Risk of HIV Infection Following Needlestick Injury: Hypothetical Model

Prevalence of HIV Infection (A)	Probability of Infection Given Needlestick Injury with Blood Containing HIV (B)	Probability of Infection Given Random Needlestick (Unknown Serostatus) $A \cdot B = (C)$	Probability of Infection Given 10 Random Needlesticks $1-(1-C)^{10}$	Probability of Infection Given 100 Random Needlesticks $1-(1-C)^{100}$
0.0001	0.001	0.0000001	0.000001	0.00001
0.0001	0.005	0.0000005	0.000005	0.00005
0.001	0.001	0.000001	0.00001	0.0001
0.001	0.005	0.000005	0.00005	0.0005
0.01	0.001	0.00001	0.0001	0.001
0.01*	0.005	0.00005	0.0005	0.005
0.05	0.001	0.00005	0.0005	0.005
0.05	0.005	0.00025	0.0025	0.025

* For example, if the prevalence of infection in the population is 0.01 (i.e., 1 per 100) and the risk of a seroconversion following a needlestick with blood known to contain HIV is 0.005 (i.e., 1 in 200), then the probability of HIV infection given a random needlestick is 0.00005 (i.e., 5 in 100,000). If an individual sustains 10 needlestick injuries, the probability of acquiring HIV infection is 0.0005 (i.e., 1 in 2,000); if the individual sustains 100 needlestick injuries, the probability of acquiring HIV infection is 0.005 (i.e., 1 in 200).

Table 2.
HIV-infected health-care workers with no reported nonoccupational risk factors and for whom case histories have been published in the scientific literature

Cases with Documented Seroconversion

Case	Occupation	Country	Type of Exposure	Source
1[*]	NS[†]	United States	Needlestick	AIDS patient
2	NS	United States	Needlestick	AIDS patient
3	NS	United States	Needlestick	AIDS patient
4	NS	United States	2 Needlesticks	AIDS patient, HIV-infected patient
5	NS	United States	Needlestick	AIDS patient
6	Nurse	England	Needlestick	AIDS patient
7	Nurse	France	Needlestick	HIV-infected patient
8	Nurse	Martinique	Needlestick	AIDS patient
9	Research lab worker	United States	Cut with sharp object	Concentrated virus
10	Home health-care worker	United States	Cutaneous[#]	AIDS patient
11	NS	United States	Nonintact skin	AIDS patient
12	Phlebotomist	United States	Mucous-membrane	HIV-infected patient
13	Technologist	United States	Nonintact skin	HIV-infected patient
14	NS	United States	Needlestick	AIDS patient
15	Nurse	Italy	Mucous membrane	HIV-infected patient
16	Nurse	France	Needlestick	AIDS patient
17	Navy medic	United States	Needlestick	AIDS patient
18	Clinical lab worker	United States	Cut with sharp object	AIDS patient

[*] AIDS case

[†] Not specified

[#] Mother who provided nursing care for her child with HIV infection; extensive contact with the child's blood and body secretions and excretions occurred; the mother did not wear gloves and often did not wash her hands immediately after exposure.

Table 2, continued.
HIV-infected health-care workers with no reported nonoccupational risk factors and for whom case histories have been published in the scientific literature

Cases without Documented Seroconversion

Case	Occupation	Country	Type of Exposure	Source
19	NS	United States	Puncture wound	AIDS patient
20	NS	United States	2 Needlesticks	2 AIDS patients
21	Research lab worker	United States	Nonintact skin	Concentrated virus
22	Home health-care provider	England	Nonintact skin	AIDS patient
23	Dentist	United States	Multiple needlesticks	Unknown
24*	Technician	Mexico	Multiple needlesticks and mucous-membrane	Unknown
25	Lab worker	United States	Needlestick, puncture wound	Unknown

* AIDS case

Table 3. Summary of Task Categorization and Implications for Personal Protective Equipment

Joint Advisory Notice Category[1]	Nature of Task/Activity	Personal protective equipment should be:	
		Available?	Worn?
I.	Direct contact with blood or other body fluids to which universal precautions apply	Yes	Yes
II.	Activity performed without blood exposure but exposure may occur in emergency	Yes	No
III.	Task/activity does not entail predictable or unpredictable exposure to blood	No	No

[1] U.S. Department of Labor, U.S. Department of Health and Human Services. Joint advisory notice: protection against occupational exposure to hepatitis B virus (HBV) and human immunodeficiency virus (HIV). Washington, DC: US Department of Labor, US Department of Health and Human Services, 1987.

Table 4. Examples of Recommended Personal Protective Equipment for Worker Protection Against HIV and HBV Transmission[1] in Prehospital[2] Settings

Task or Activity	Disposable Gloves	Gown	Mask[3]	Protective Eyewear
Bleeding control with with spurting blood	Yes	Yes	Yes	Yes
Bleeding control with minimal bleeding	Yes	No	No	No
Emergency childbirth	Yes	Yes	Yes, if splashing is likely	Yes, if splashing is likely
Blood drawing	At certain times[4]	No	No	No
Starting an intravenous (IV) line	Yes	No	No	No
Endotracheal intubation, esophageal obturator use	Yes	No	No, unless splashing is likely	No, unless splashing is likely
Oral/nasal suctioning, manually cleaning airway	Yes[5]	No	No, unless splashing is likely	No, unless splashing is likely
Handling and cleaning instruments with microbial contamination	Yes	No, unless soiling is likely	No	No
Measuring blood pressure	No	No	No	No
Measuring temperature	No	No	No	No
Giving an injection	No	No	No	No

[1] The examples provided in this table are based on application of universal precautions. Universal precautions are intended to supplement rather than replace recommendations for routine infection control, such as handwashing and using gloves to prevent gross microbial contamination of hands (e.g., contact with urine or feces).

[2] Defined as setting where delivery of emergency health care takes place away from a hospital or other health-care facility.

[3] Refers to protective masks to prevent exposure of mucous membranes to blood or other potentially contaminated body fluids. The use of resuscitation devices, some of which are also referred to as "masks," is discussed on page 23.

[4] For clarification see Appendix A, page 7, and Appendix B, page 7.

[5] While not clearly necessary to prevent HIV or HBV transmission unless blood is present, gloves are recommended to prevent transmission of other agents (e.g., *Herpes simplex*).

Table 5. Reprocessing Methods for Equipment Used in the Prehospital[1] Health-Care Setting

terilization:	Destroys:	All forms of microbial life including high numbers of bacterial spores.
	Methods:	Steam under pressure (autoclave), gas (ethylene oxide), dry heat, or immersion in EPA-approved chemical "sterilant" for prolonged period of time, e.g., 6–10 hours or according to manufacturers' instructions. Note: liquid chemical "sterilants" should be used only on those instruments that are impossible to sterilize or disinfect with heat.
	Use:	For those instruments or devices that penetrate skin or contact normally sterile areas of the body, e.g., scalpels, needles, etc. Disposable invasive equipment eliminates the need to reprocess these types of items. When indicated, however, arrangements should be made with a health-care facility for reprocessing of reusable invasive instruments.
ligh-Level Disinfection:	Destroys:	All forms of microbial life except high numbers of bacterial spores.
	Methods:	Hot water pasteurization (80–100 C, 30 minutes) or exposure to an EPA-registered "sterilant" chemical as above, except for a short exposure time (10 – 45 minutes or as directed by the manufacturer).
	Use:	For reusable instruments or devices that come into contact with mucous membranes (e.g., laryngoscope blades, endotracheal tubes, etc.).
ntermediate-Level Disinfection:	Destroys:	*Mycobacterium tuberculosis*, vegetative bacteria, most viruses, and most fungi, but does not kill bacterial spores.
	Methods:	EPA-registered "hospital disinfectant" chemical germicides that have a label claim for tuberculocidal activity; commercially available hard-surface germicides or solutions containing at least 500 ppm free available chlorine (a 1:100 dilution of common household bleach – approximately ¼ cup bleach per gallon of tap water).
	Use:	For those surfaces that come into contact only with intact skin, e.g., stethoscopes, blood pressure cuffs, splints, etc., and have been visibly contaminated with blood or bloody body fluids. Surfaces must be precleaned of visible material before the germicidal chemical is applied for disinfection.

Table 5. Reprocessing Methods for Equipment Used in the Prehospital[1] Health-Care Setting – Continued

Low-Level Disinfection:	Destroys:	Most bacteria, some viruses, some fungi, but not *Mycobacterium tuberculosis* or bacterial spores.
	Methods:	EPA-registered "hospital disinfectants" (no label claim for tuberculocidal activity).
	Use:	These agents are excellent cleaners and can be used for routine housekeeping or removal of soiling in the absence of visible blood contamination.
Environmental Disinfection:		Environmental surfaces which have become soiled should be cleaned and disinfected using any cleaner or disinfectant agent which is intended for environmental use. Such surfaces include floors, woodwork, ambulance seats, countertops, etc.

IMPORTANT: To assure the effectiveness of any sterilization or disinfection process, equipment and instruments must first be thoroughly cleaned of all visible soil.

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[1] Defined as setting where delivery of emergency health-care takes place prior to arrival at hospital or other health care facility.

"HIV Epidemic and AIDS: Trends in Knowledge — United States, 1987 and 1988," Morbidity and Mortality Weekly Report, May 26, 1989, Vol. 38, No. 20

Summary

This article describes data about the level of knowledge the general public has about AIDS and the HIV epidemic. It identifies areas of increasing knowledge as well as misinformation that must be addressed through increased education efforts. Key data are that from 1987 to 1988:

- Accurate knowledge about how HIV is and is not transmitted increased;
- The increases in the percentages of adults who considered it "very unlikely" or "definitely not possible" to transmit HIV through various forms of casual contact were significant;
- The proportion of adults who reported discussing AIDS with their children aged 10-17 years remained at 60%, but the proportion who reported that their children had received AIDS education in school increased from 36% to 59%.

Assuring that school board members have accurate information about AIDS and the HIV epidemic is critical if school boards are to make sound decisions about policy and curriculum. The survey questions on which this article is based provide guidance on subjects to address in a briefing for school board members.

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MORBIDITY AND MORTALITY WEEKLY REPORT

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Current Trends

HIV Epidemic and AIDS: Trends in Knowledge – United States, 1987 and 1988

Education and information can play an important role in preventing human immunodeficiency virus (HIV) transmission by reducing high-risk behaviors and encouraging safe practices. To collect information for developing and targeting new education programs, the National Health Interview Survey (NHIS) began in August 1987 to include specific questions to assess the public's knowledge about the transmission, prevention, and consequences of HIV infection; attitudes toward persons already infected; and awareness and utilization of the HIV-antibody test.

NHIS is a continuous, cross-sectional household interview survey conducted by CDC's National Center for Health Statistics (NCHS). Each week, a national probability sample of the civilian, noninstitutionalized population is interviewed by Bureau of the Census personnel to obtain information on health, demographic, and other characteristics of each household member. Supplemental information is collected for all or a sample of household members. The 1987 and 1988 NHIS acquired immunodeficiency syndrome (AIDS) knowledge and attitudes questionnaires were administered to one randomly chosen adult ≥18 years of age in each household. The estimates in this report are based on the approximately 3500 interviews completed each month.

The first NHIS AIDS Knowledge and Attitudes Survey was implemented from August to December 1987, and provisional survey results were published monthly (*1–5*). From January to April 1988, the NHIS AIDS questionnaire was revised to include questions about the brochure, "Understanding AIDS," which was mailed to every U.S. household in May and June. The revised AIDS Knowledge and Attitudes Survey was implemented in May 1988, and provisional results are being published periodically (*6–9*).

The current questionnaire contains items on self-assessed knowledge about AIDS, HIV transmission, perceived effectiveness of various preventive measures, experience with blood donation and testing, and self-assessed likelihood of being seropositive. In the survey, the term "AIDS virus" was used in place of HIV, and that wording has been maintained in this report. All estimates in this report are provisional. Unless otherwise indicated, all changes and differences cited in the text are statistically significant (p<0.05).

HIV and AIDS – Continued

BASELINE FINDINGS

In August 1987, the proportions of U.S. adults who responded that they knew "a lot" and "some" about AIDS were 20% and 40%, respectively (Table 1). Sixty-seven percent of adults had discussed AIDS with a friend or relative; of those adults who had children 10–17 years of age, 60% had discussed AIDS with their children; 36% reported that their children had received AIDS education in school (Table 1).

Most adults answered that they had "no" chance (60%) or a "low" chance (30%) of acquiring the AIDS virus (Table 1). Although 70% of adults had heard of the blood test to detect the presence of HIV antibody, only 15% had had their blood tested, including 7% who reported having had their blood tested and 8% who reported having donated blood since 1985, when routine testing of donation began.

Thirty-four percent of adults considered use of a condom as "very effective" in preventing HIV infection, and 84% answered that having a monogamous relationship with an uninfected partner is a "very effective" preventive measure (Table 1). Two percent of adults responded that use of a diaphragm or spermicidal jelly, foam, or cream are "very effective" preventive techniques.

Most adults knew that AIDS is a fatal disease and that no cure for AIDS exists (89% and 83%, respectively) (Figure 1). Seventy-five percent answered that it was "definitely true" that the AIDS virus can be transmitted during sexual intercourse; 69%, that it was "definitely true" that a pregnant woman can pass the AIDS virus to her baby; 91%, that it was "very likely" that a person would acquire the AIDS virus from sharing needles for drug use with a person who has AIDS (not shown in the figure). The proportions of adults who responded that it was either "probably true" or "somewhat likely" that HIV could be transmitted in these three ways were 18%, 22%, and 5%, respectively.

Sixty-five percent of the adults responded that the following were "definitely false": a vaccine is available to the public that protects against the AIDS virus; AIDS is especially common in older persons; and it is possible to tell by looking at someone if he or she has the AIDS virus.

Seventy-four percent of respondents answered that it is "very unlikely" or "definitely not possible" to transmit the AIDS virus by living near a hospital or home for AIDS patients; 58%, by attending school with a child who has the AIDS virus; 53%, by working near someone with the AIDS virus; 40%, by using public toilets; and 27%, by sharing eating utensils with someone who has the AIDS virus (Figure 2).

CHANGES BETWEEN AUGUST 1987 AND AUGUST 1988

Between August 1987 and August 1988, both objective and self-assessed measures of knowledge increased (Figure 1). Over this period, the proportion of adults who answered that it was "definitely true" that AIDS is an infectious disease caused by a virus increased from 44% to 64%. The proportion responding that it was "definitely true" that a pregnant woman can transmit HIV to her baby increased from 69% to 80%. The proportion answering that it was "definitely false" that a vaccine exists that protects against HIV infection increased from 65% to 76%. The proportion of adults responding that they knew "a lot" about AIDS increased from 20% to 22%; adults answering that they knew "some" about AIDS increased from 40% to 44% (Table 1).

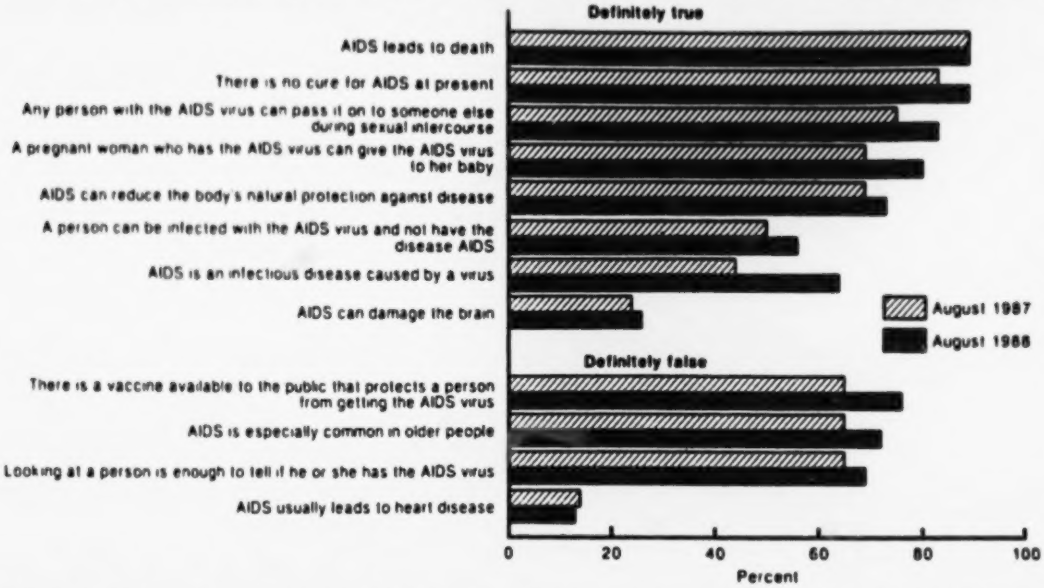
A substantial increase occurred in the proportion of adults who answered that the AIDS virus could *not* be transmitted through casual contact with infected persons (Figure 2). In August 1987, 35% of adults responded it was "very unlikely" that a person could become infected with the AIDS virus by working near someone with it, *HIV and AIDS — Continued*

TABLE 1. Measures of knowledge, attitudes, and behaviors among adults surveyed about HIV and AIDS — United States, August 1987 and August 1988

Measure of knowledge	August 1987 (%)	August 1988 (%)
Self-perceived level of knowledge about AIDS:		
A lot	20	22
Some	40	44
A little	30	26
None	10	7
Percentage of adults who:		
Have ever heard of a blood test that can detect the AIDS virus infection	70	75
Have ever had their blood tested for the AIDS virus infection	15	17
Expect to have a blood test for the AIDS virus infection in the next 12 months	3	4
Have ever discussed AIDS with a friend or relative	67	65
Have ever discussed AIDS with their children aged 10-17	60	60
Report that their children aged 10-17 have received AIDS education in school	36	59
Self-perceived risk of getting the AIDS virus:		
High	1	0
Medium	4	2
Low	30	20
None	60	75
Don't know	5	3
Perceived effectiveness of selected methods of preventing AIDS virus transmission through sexual activity:		
Using a diaphragm —		
Very effective	2	2
Somewhat effective	11	12
Not at all effective	56	57
Don't know	31	29
Using a condom —		
Very effective	34	29
Somewhat effective	48	54
Not at all effective	6	4
Don't know	12	12
Using a spermicidal jelly, foam, or cream —		
Very effective	2	1
Somewhat effective	13	14
Not at all effective	54	55
Don't know	31	30
Two people who do not have the AIDS virus having sex *only* with each other —		
Very effective	84	84
Somewhat effective	9	7
Not at all effective	1	2
Don't know	6	8

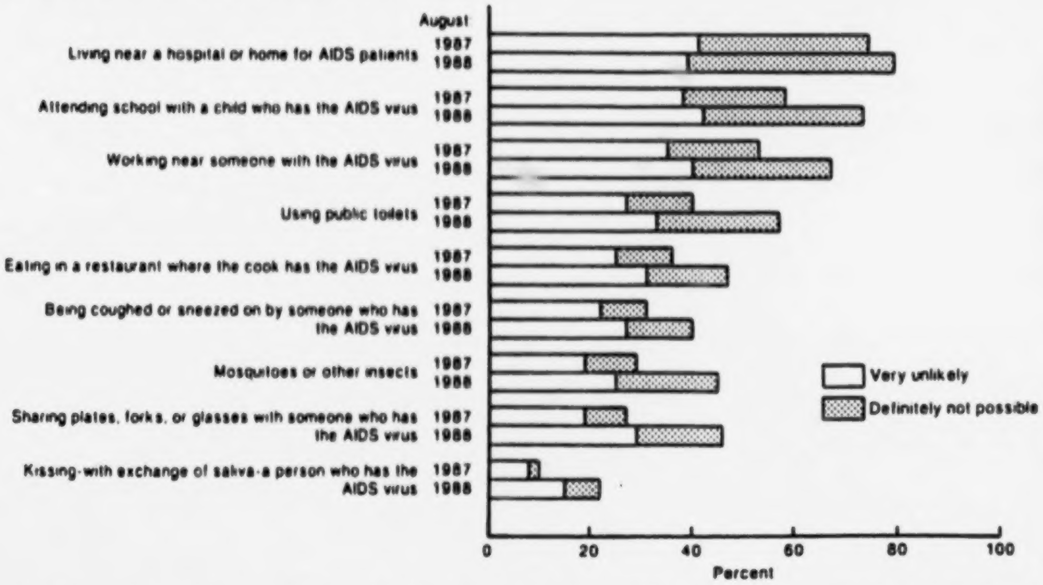
HIV and AIDS – Continued

FIGURE 1. Provisional estimates of percentage of adults responding correctly to selected AIDS knowledge items – United States, August 1987 and August 1988



SOURCE: National Center for Health Statistics, Division of Health Interview Statistics, National Health Interview Survey.

FIGURE 2. Provisional estimates of percentage of adults who think it very unlikely or definitely not possible to transmit the AIDS virus in selected ways – United States, August 1987 and August 1988



SOURCE: National Center for Health Statistics, Division of Health Interview Statistics, National Health Interview Survey.

and 18% responded that it was "impossible." In August 1988, these proportions had increased to 40% and 27%, respectively.

The perceived effectiveness of condoms ("very effective" or "somewhat effective") in preventing HIV transmission remained essentially the same (Table 1), as did attitudes about the other forms of contraception and the perceived "effectiveness" of a mutually monogamous relationship with an uninfected partner.

The proportion of adults who had heard of the blood test for early diagnosis increased from 70% to 75%. In August 1988, 17% of adults had been tested, including 9% who reported having had their blood tested and 8% who reported having donated blood since 1985.

The proportion of adults reporting their chances of becoming infected with HIV as "high" or "medium" showed limited change (1% to <1% [nonsignificant], 4%–2%, respectively), but a large proportion shifted from the low-risk to no-risk category, the latter increasing from 60% to 75%.

Three percent of adults reported that they belonged to one or more of the groups associated with increased risk for HIV transmission. Among these persons, perceived risk for HIV transmission varied: 5% reported that their chances of already having been or of becoming infected with HIV were "high," 7% reported a "medium" chance, and 42% reported a "low" chance of infection.

The proportion of adults who reported discussing AIDS with their children aged 10–17 years remained at 60%; in contrast, the proportion who reported that their children had received AIDS education in school increased from 36% to 59%. Little change occurred in the proportion who reported having discussed AIDS with friends or relatives.

Reported by: Div of Health Interview Statistics, National Center for Health Statistics; National AIDS Information and Education Program, Office of the Deputy Director (HIV), CDC.

Editorial Note: In comparing August 1987 to August 1988, the most substantial increase in knowledge was related to transmission of HIV. The increases in the percentages of adults who considered it "very unlikely" or "definitely not possible" to transmit HIV through various forms of casual contact represent important gains in knowledge.

The overall gain in levels of knowledge about HIV and AIDS coincided with the national multimedia public awareness campaign. Analysis of the NHIS data is under way to assess the impact of one element of this campaign, the mailing of the brochure entitled "Understanding AIDS" to every U.S. household during May and June 1988. Evaluation of this and other public education efforts will help guide future campaigns so that progress can continue.

References

1. NCHS, Dawson DA, Cynamon M, Fitti JE. AIDS knowledge and attitudes: provisional data from the National Health Interview Survey—United States, August 1987. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, 1987; DHHS publication no. (PHS)88-1250. (Advance data from vital and health statistics; no. 146).
2. NCHS, Dawson DA, Cynamon M, Fitti JE. AIDS knowledge and attitudes for September 1987: provisional data from the National Health Interview Survey. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, 1987; DHHS publication no. (PHS)88-1250. (Advance data from vital and health statistics; no. 148).
3. NCHS, Dawson DA, Cynamon M, Fitti JE. AIDS knowledge and attitudes for October 1987: provisional data from the National Health Interview Survey. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, 1988; DHHS publication no. (PHS)88-1250. (Advance data from vital and health statistics; no. 150).

HIV and AIDS – Continued

4. NCHS, Dawson DA, Thornberry OT. AIDS knowledge and attitudes for November 1987: provisional data from the National Health Interview Survey. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, 1988; DHHS publication no. (PHS)88-1250. (Advance data from vital and health statistics; no. 151).
5. NCHS, Dawson DA, Thornberry OT. AIDS knowledge and attitudes for December 1987: provisional data from the National Health Interview Survey. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, 1988; DHHS publication no. (PHS)88-1250. (Advance data from vital and health statistics; no. 153).
6. NCHS, Dawson DA. AIDS knowledge and attitudes for May and June 1988: provisional data from the National Health Interview Survey. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, 1988; DHHS publication no. (PHS)88-1250. (Advance data from vital and health statistics; no. 160).
7. NCHS, Dawson DA. AIDS knowledge and attitudes for July 1988: provisional data from the National Health Interview Survey. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, 1988; DHHS publication no. (PHS)88-1250. (Advance data from vital and health statistics; no. 161).

(Continued on page 363)

HIV and AIDS – Continued

8. NCHS, Dawson DA. AIDS knowledge and attitudes: August 1988 – provisional data from the National Health Interview Survey. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, 1988; DHHS publication no. (PHS)89-1250. (Advance data from vital and health statistics; no. 163).
9. NCHS, Fitti JE. AIDS knowledge and attitudes for September 1988: provisional data from the National Health Interview Survey. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, 1989; DHHS publication no. (PHS)89-1250. (Advance data from vital and health statistics; no. 164).

Adolescents, AIDS, and HIV: Guidelines for Review, Center for Population Options, 1989.

Summary

These guidelines are designed to assist educators in reviewing HIV prevention and AIDS education materials for use with adolescents.

The guidelines recommend criteria for reviewing:

- the accuracy of information;
- whether the material is appropriately designed for a targeted audience;
- whether the terminology used is correct and consistent; and
- whether the information is presented in a positive manner.

A two-page checklist based on the recommended criteria is provided.

These guidelines could be incorporated into Activity 7: Criteria for Effective HIV Education. They can be quoted or reproduced if credit to the Center for Population Options is provided. For example, you may want to reproduce the two-page checklist and include it in the Participant Notebook (following pages 15-16). Or, you may want to simply provide the guidelines as an additional handout that participants can take home to share with their educational staff.

CPO guidelines for reviewing HIV prevention and AIDS education materials for use with adolescents.

Adolescents, AIDS and HIV Guidelines for Review

Adolescents are exposed to an enormous amount of information and misinformation about HIV infection and AIDS. Because risk taking behavior is typical of the adolescent years and this behavior frequently involves experimentation with drugs and sex, public health officials believe adolescents are at high risk for HIV infection.

A multitude of educational materials has been developed for the adolescent audience. While many of these materials are of high quality, some are inaccurate or inadequate. The continual discovery of new information about HIV leads to a short life span for HIV education materials and the consequent need for constant review and updating of the available products.

To facilitate the process of reviewing HIV education materials, the Education and Training staff of the Center for Population Options (CPO) have developed the following guidelines. CPO's experience in resource evaluation has been demonstrated in the production of the CPO National HIV Prevention Project publication series, *Adolescents, AIDS and HIV: Resources for Educators*.

These guidelines have been reviewed by CPO's Centers for Disease Control National HIV Prevention Project Review Committee, and are used to review materials considered for listing in *Resources for Educators*. The guidelines are summarized on the Check Sheet, designed to be duplicated and used to simplify the evaluation process, and to allow for easy comparison among materials being considered for use and/or purchase. CPO recommends that teachers and group leaders carefully review materials before using them and that they include adolescents from the target audience in the review process.

It is essential that teachers and group leaders be prepared to teach HIV prevention. They need to be well trained in human sexuality and have the skills to teach about HIV in a sensitive manner. Training should include exploration and clarification of their own values about sexuality to enable them to teach without imposing their personal values on students. They will need to work effectively with parents and community groups on the presentation of sensitive information.

Because of limited funding, it is sometimes necessary to continue using HIV education materials that are slightly out of date. Such materials can still be used in an effective education program. While the fields of research and treatment of HIV are rapidly changing, the messages on prevention and transmission have remained constant. Teachers and group leaders can use new HIV information as a teaching tool. By pointing out and discussing any information that has changed or been clarified, the leader can take advantage of the opportunity to reinforce the essential HIV prevention and transmission messages and help adolescents understand the newly emerging information and reasons for the changes.

Accurate Information

To determine if information is accurate and current it may be compared with reports affirmed by the U.S. Department of Health and Human Services Centers for Disease Control (CDC), such as the *Morbidity and Mortality Weekly Report* (MMWR), the *Surgeon General's Report on Acquired Immune Deficiency Syndrome* and the CDC's *America Responds to AIDS* campaign. Also, the National AIDS Hotline is available 24 hours a day at 1-800-342-AIDS.

There are a number of information pamphlets on HIV/AIDS for the general public. Two excellent examples are the *Surgeon General's Report on Acquired Immune Deficiency Syndrome* and the "Understanding AIDS" booklet mailed by the U.S. Department of Health and Human Services to every household in America. For further information on these and other resources available from the U.S. Government, contact the National AIDS Information Clearinghouse.(1)

Targeted Information

For maximum effectiveness and impact, materials should be specifically designed for a particular audience. These materials need to be appropriate in terms of age and developmental level. Materials also need to be sensitive to the target audience. Considerations should include cultural and ethnic background, sexual orientation, prevalence of IV drug use, levels of sexual activity, school status (enrolled, graduated or dropped out) literacy levels and employment status.

Language and illustrations need to be acceptable and sensitive to community values and needs, without compromising the effectiveness of the prevention message. Information must be presented in words and images youth can relate to and understand. Involvement of adolescents from the target audience in the review process will greatly enhance the selection of effective materials.

A guide for matching approaches to AIDS education with childhood development along with criteria for evaluating an AIDS curriculum has been developed by the National Coalition of Advocates for Students.(2) To help determine the reading level of printed materials, there are many easy to use readability formulas such as McLaughlin's "SMOG Readability Formula," the "Fry Readability Graph" and the "Gunning Fog Index." These formulas, along with information on readability formula software for computers, are available at public libraries.

Terminology

The way in which words are used can have an important role in shaping attitudes and actions. Published materials should use current terminology. This terminology should be used consistently and correctly throughout any materials.

In presenting a prevention message, the terms "HIV," "HIV infection," and "HIV epidemic" more correctly identify the problem being addressed. The final manifestation of HIV infection is the disease AIDS. AIDS is not transmitted, HIV is. Also, people do not die from AIDS, they die from complications related to the opportunistic infections to which people with HIV infection are susceptible.

In discussing transmission of HIV, emphasis should be placed on risk behaviors instead of risk groups. It is specific *behaviors* with infected individuals that place one in danger of being infected with HIV, not inclusion in a particular group of people.

While discussing sexual transmission, young people need to hear very specifically which body fluids do and do not transmit HIV and which behaviors place them at increased risk for HIV infection. Phrases such as, "body fluids transmit HIV during intimate sexual contact" are so vague that they do more to confuse than to educate. Specific references to blood, semen and vaginal secretions are recommended.

It is important to acknowledge that differences may exist within your target population. In order to assure all members of an audience feel included, non-specific identification of sexual partners is advised. Generic references such as "one's partner" are recommended and the use of "he/she" pronouns should be avoided. Information should address and acknowledge differences in individual lifestyle and individual sexual orientation in a positive tone. Materials and educational approaches which disregard this fact serve to further isolate an already isolated, and notably vulnerable to HIV infection, population of gay and lesbian youth.

Materials should discuss people with AIDS/HIV infection or people living with AIDS/HIV infection rather than "AIDS victims," "innocent victims," or "AIDS patients." These terms cast judgment on lifestyles or behaviors. The terms "AIDS patient" and "AIDS victim" imply all people with AIDS/HIV infection are sick and under medical care and not successfully coping with their disease. Many people with AIDS/HIV infection are without symptoms of disease and lead productive lives. A source for frequently used, appropriate, terminology is "The AIDS Style Sheet," published by FOCUS, AIDS Health Project.(3)

Tone

Information should be presented in a positive manner. The focus of materials should be on preventing further HIV infection rather than on attributing the origins of HIV to any particular place or group of people. Young people need to understand their risk of becoming infected with HIV, the consequences of HIV infection, as well as the role which substance abuse plays as a co-factor to high risk behaviors. They need to be encouraged to respond with compassion to people infected with HIV. And, most importantly, youth need to know there are many behavior options, including safer sex practices, that are healthy and can provide fun and pleasure, which do not expose them to HIV infection.

Finally, it is important to stress that no single pamphlet or movie is a complete HIV education program. HIV prevention and AIDS education programs need to be part of comprehensive health promotion programs for youth. Materials such as movies, audio tapes and pamphlets are excellent tools to trigger discussion and/or to provide reinforcement for information previously discussed. They are *not* complete programs by themselves. AIDS education and HIV information can quickly raise issues that are complex, powerful and personal. Programs which allow for open examination of these concerns plus opportunities for questioning in both public and private forums will be most effective in helping adolescents make the choices and use the skills necessary to avoid HIV infection.

Notes

1. National AIDS Information Clearinghouse, P.O. Box 6003, Rockville, MD 20850. Phone: (301)762-5111
2. National Coalition of Advocates for Students, 100 Boylston St., No. 737, Boston, MA 02116.
3. FOCUS, AIDS Health Project, Box 0884, San Francisco, CA 94143-0884.

HIV AND AIDS MATERIALS AVAILABLE FROM CPO

Resources: adolescents, AIDS and HIV

Peer Education: Teens Teaching Teens About AIDS and HIV Infection Prevention – A detailed analysis of peer education theory and strategy, including practical information about setting up programs. (April 1989, $5.00)

Resources for Educators – A series of annotated bibliographies of quality education materials about HIV and AIDS. Three editions now available – a fourth is in process. (1987-1988; $3.50 apiece)

Factsheet: Adolescents, AIDS and HIV – quick statistical snapshot of the HIV epidemic as it relates to teens. (one copy free, bulk rates available)

Advice from TEENS. . .on Buying Condoms – Written by teens for teens, this pamphlet uses cartoons and simple language to address the confusion, nervousness and fear that many teens experience when purchasing condoms. (1988, 1-40, $.25, 41+, $.20)

The Time for Prevention is Now – This popular report, well into its second printing, decribes the threat of AIDS to adolescents and suggests strategies for involving community groups in implementing HIV prevention initiatives. (1987: $10.00)

Life Planning Education

Life Planning Education Curriculum – CPO's innovative curriculum integrates sexuality education and employment planning. (Revised 1988; $35.00)

Make a Life for Yourself – A booklet for teens, with ideas from the Life Planning curriculum demonstrated through fun, self-explanatory excercises. (Revised March, 1989; single copies, $1.00. Bulk rates available)

Research and analysis

The Changing Face of AIDS: Adolescents and HIV Infection – An overview of the problem of adolescents, AIDS and HIV, prepared for editorial boards at top newspapers across the country. (February, 1989, $1.00)

Teens' Survey of Stores in the District of Columbia on Accessibility of Family Planning Methods – CPO's Teen Council conducted the research for this report, surveying condom and other contraceptive accessibility in 60 drug and convenience stores in Washington, DC. (1988, $1.00)

D.C. Teenagers and AIDS: Knowledge, Attitudes, and Behavior – This analysis of four focus groups of Washington, D.C. teenagers shows that teens who know the facts about AIDS and HIV infection do not necessarily change their behavior. (1988, $1.00)

CENTER FOR POPULATION OPTIONS

The Center for Population Options is a nonprofit educational organization dedicated to improving the quality of life for adolescents by preventing too-early childbearing. CPO's national and international programs seek to improve adolescent decision-making through "life planning" and other educational programs, to improve access to reproductive health care, to promote the development of school-based clinics, and to prevent the spread among adolescents of HIV and other sexually transmitted diseases. CPO's National HIV Prevention Project promotes exchange of information and development of innovative strategies to prevent the HIV epidemic from reaching young people.

These guidelines were prepared by Mark A. Weber, Program Associate. Special thanks go to CPO staff who provided assistance.

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Guidelines for Review: Check Sheet

Type of material reviewed: ______________________________
(pamphlet, book, video, cassette, etc.)

Title of material reviewed: ______________________________
____

Target audience: ______________________________

Reading level: ______________ Publication date: ______________

Published by: ______________________________

Cost: ______________________________

Publisher's address:
____
____

Publisher's phone: ______________________________

Considering the target audience and reading level, the HIV information presented:

______ Provides accurate knowledge about HIV infection and the disease AIDS.

______ Reduces misinformation about HIV infection and the disease AIDS.

______ Promotes compassion for individuals who are already infected with HIV or have AIDS.

______ Encourages adolescents to delay the initiation of sexual intercourse.

______ Encourages adolescents who are having intercourse of any type:

  ______ A) to know about condoms.

  ______ B) to know how to use condoms properly.

  ______ C) to recognize the limitations of condoms.

______ Offers behaviors other than intercourse to express sexual feelings.

______ Encourages the elimination of:

  ______ A) experimentation with and use of drugs, including alcohol.

  ______ B) misuse of drugs, including alcohol.

______ Offers information on treatment of drug addiction.

______ Warns against sharing intravenous (IV) needles and syringes for any reason -- including ear piercing, tattooing, taking steroids and other injected substances -- and against sharing other blood-contaminated items such as razors.

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_____ Offers information about sterilizing needles and syringes in combination with information on treatment of drug addiction.

_____ Promotes pre-test and post-test counseling as an essential component of HIV antibody testing.

Considering the target audience and reading level, the material is:

_____ Appropriate in terms of age and developmental level.

_____ Sensitive to the makeup of the target audience.

_____ Appropriate in terms of language and illustrations that the targeted youth can relate to and understand.

Considering the target audience and reading level, the terminology consistently and correctly:

_____ Emphasizes risk behaviors, not risk groups.

_____ Discusses specifically which body fluids transmit HIV.

_____ Discusses specifically which body fluids do not transmit HIV.

_____ Discusses specifically which behaviors increase risk for HIV infection.

_____ Uses generic references such as "one's partner," avoiding the use of he/she pronouns.

_____ Refers to "people with AIDS/HIV infection" or "people living with AIDS/HIV infection," and not to AIDS victims or AIDS patients, nor does it classify subgroups of individuals as "innocent victims." (Use of the terminology "AIDS patient" is appropriate in a medical care context.)

Overall effect:

_____ Information is presented in a positive tone with emphasis on what can be done to prevent further HIV infection.

Target audience's comments:

____

____

____

Reviewer's general comments:

____

____

____

Approved:__________ Rejected: __________

Reviewer:____________________________ Date:____________________________

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The Facts

ADOLESCENTS, AIDS, AND THE HUMAN IMMUNODEFICIENCY VIRUS

Overview

Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immunodeficiency Syndrome (AIDS), is an epidemic in the United States, affecting all sectors of society. Many public health officials believe that teenagers, because of their experimentation with sex and drugs, are at increasingly high risk of being infected with HIV.

Terminology

The Presidential Commission on the Human Immunodeficiency Virus Epidemic has determined that use of the term "AIDS" no longer adequately describes the scope of the public health problem society faces. The Commission's final report stated: "The term 'AIDS' is obsolete. 'HIV infection' more correctly defines the problem. . . . Continued focus on the label 'AIDS' contributes to the lack of understanding of the importance of HIV infection as the more significant element for taking control of the epidemic."

Status of HIV Infection in the United States

- An estimated 1 to 1.5 million Americans are infected with HIV.[1]
- As of September 19, 1988, 73,394 cases of AIDS in the U.S. and 41,393 deaths caused by AIDS had been reported to the Centers for Disease Control.[2]
- The U.S. Public Health Service predicts there will be 365,000 diagnosed cases of AIDS and 263,000 deaths caused by AIDS reported to the Centers for Disease Control by the end of 1992.[1]
- Cases of heterosexually transmitted AIDS are expected to increase twenty-fold over the next five years.[3]

HIV Infection Among Teenagers and Young Adults

- As of September 19, 1988, 295 cases of AIDS among teenagers were reported to the Centers for Disease Control. Of the teenagers infected, 48 percent are white, 33 percent are black, 17 percent are Hispanic and 2 percent are of other races.[2]
- Almost one-fourth of people with AIDS are in their twenties.[2] Because the latency period between HIV infection and onset of symptoms is about seven years,[4] many of these people probably contracted the HIV virus as teenagers.[5]
- AIDS cases among 13-19 year olds increased by 54 percent between January and November 1987.[6]
- A greater proportion of adolescents than adults with AIDS are female (14 percent vs. 7 percent), are Black and Hispanic (53 percent vs. 38 percent) and were infected with HIV through heterosexual contact (9 percent vs. 4 percent).[7]
- In New York City, AIDS is the leading cause of death for women ages 25-34; for women ages 15-24, it's the fourth most common cause of death.[8]

Teens at Risk

Sexual Intercourse

- On average, young women first engage in sexual intercourse when they are 16.2 years old. For young men, the average age of first intercourse is 15.7 years old.[9]
- For most young men and women, the decision to have sex is spontaneous. Only 17 percent of young women and 25 percent of young men report planning their first act of intercourse.[9]
- One in six high school girls engaging in sexual intercourse has had at least four different sexual partners.[10]
- A 1986 study of homosexual male teenagers found they had about seven sexual partners a year. The sexual partners were an average of seven years older than the teenagers.[11]

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OCTOBER 1988

Sexually Transmitted Diseases

- A recent study shows that people with a history of sexually transmitted diseases (STDs) have a higher incidence of HIV infection than people with no such history.[12]
- Each year, 2.5 million teenagers contract a STD—that's about one teenager in every six.[10]
- While latex condoms, used consistently and correctly, are not 100 percent effective in protecting against HIV infection, they do provide the best protection available for people engaging in sexual intercourse.[13]
- Only 24 percent of sexually active women ages 15-19 use contraception consistently. Of the young women using contraception, only 21 percent protect themselves against STDs by using condoms.[14]
- In a recent study of Washington, D.C. drug and convenience stores, teenagers found it difficult to find and buy condoms and females had more negative experiences buying condoms than males.[15]

Drug and Alcohol Use

- The use of drugs and alcohol impairs a person's willingness and ability to use condoms or other precautions while having sex.[11]
- About one-fourth of the 8th grade students (26 percent) and more than one-third of the 10th grade students (38 percent) report having had five or more drinks on one occasion during the previous two weeks.[16]
- About one out of every fifteen adolescents has tried cocaine.[16]
- In a 1987 study conducted for the National Institute on Drug Abuse, 1.2 percent of U.S. high school seniors reported having used heroin.[17]

Runaways and Prostitution

- About one million U.S. teenagers run away from home each year.[18]
- An estimated 187,500 runaways are involved in illegal activities, such as drug use, trafficking or prostitution.[18]
- An estimated 125,000-200,000 teenage men and women become involved in prostitution each year; approximately one-third of these young people are not runaways.[19]

Knowledge and Attitudes About HIV Infection/Prevention

- The 1987 National Adolescent Student Health Survey of eighth and tenth graders revealed that:
    - More than one-third of the students did not know the common early signs of STDs.
    - More than one-half of the students did not know that birth control pills do not provide protection against STDs.
    - Two-thirds of the students (67 percent) did not know that washing after sex is an ineffective way of avoiding STDs.[16]
- A 1987 NBC poll found that 91 percent of adults approve of teaching AIDS prevention to children in public schools.[20]
- Of these same adults, 79 percent favor the use of television advertisements to promote the use of condoms for AIDS prevention.[20]
- More than 87 percent of teens in an urban study agree that it is important for students to receive AIDS education instruction through the school curriculum.[21]

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CRITERIA FOR EVALUATING AN AIDS CURRICULUM (1988)

National Coalition of Advocates for Students (NCAS)

Adolescents and young adults are now a primary risk group for contracting acquired immmunodeficiency syndrome (AIDS). At least 50% of all teenagers are sexually active; most will have more than one sexual partner, and some will be experimenting with drugs. Regardless of whether adults approve of this behavior, young people's lives may be at risk. Public schools must assume a key role in giving youth the information they need to avoid contracting this deadly disease.

Teaching about AIDS should take place within the context of a comprehensive health education or family life/sex education course. Such a course should present the positive aspects of sexuality as well as its dangers. An AIDS curriculum must be appropriate to the chronological and developmental age of the student as suggested in Attachement A, and should be taught in small classroom-size groups of 20 or fewer students.

Below is a checklist for parents, child advocates, school board members, teachers and administrators to use to evaluate existing AIDS curricula and to advocate for the establishment of high quality curricula. An effective AIDS curriculum should elicit "yes" answers to the following questions:

CURRICULUM CONTENT

___ For students in grades 6 and up, does the curriculum give simple, clear and direct information about AIDS transmission and prevention? (See Attachment B)

___ Does the curriculum help students acquire the necessary self-esteem and assertiveness to choose to abstain from sexual intercourse?

___ Does the curriculum inform all students about effective ways to prevent infection when they become sexually active, including information about condoms and their correct use?

___ Does the curriculum focus on teaching students how to make healthy sexual decisions and not just on the medical aspects of AIDS?

___ By emphasizing high-risk behaviors rather than high-risk groups, does the curriculum strongly convey the message that ANYONE can get AIDS regardless of race, sex, age or sexual orientation?

___ Does the curriculum affirm that people have natural sexual feelings?

___ Are several class periods provided to give each student multiple opportunities to rehearse making decisions based on the information they have learned about AIDS?

___ Does the curriculum allay young children's fears about AIDS?

___ Does the curriculum give young children a foundation for more detailed discussion of sexuality and health at the 6th grade level and later?

DEVELOPMENT AND IMPLEMENTATION

___ Does the program provide for adequate staff training to teach the curriculum? (See Attachment C)
--Are staff helped to examine their own attitudes about sexuality and AIDS?
--Are staff given accurate and detailed information about AIDS?
--Are staff trained in the concrete skills needed to teach effectively an AIDS curriculum?

___ Is the same information given to limited English proficient students in their own language?

___ Is the information provided appropriately to students with hearing and visual impairments and to students with severely disabling conditions?

___ Is the curriculum updated regularly to incorporate new information as it becomes available?

___ Has sufficient community and parental support been generated to give teachers the backing they need to teach sensitive material in a direct manner?

___ Does the curriculum facilitate an on-going dialogue with parents on these issues? (See Attachment D)

Attachment A: MATCHING APPROACHES TO AIDS EDUCATION WITH CHILDHOOD DEVELOPMENT

Students in a particular grade may vary widely in their emotional development. Teachers are urged to individualize their teaching where appropriate, while keeping in mind that the following statements are apt to characterize the vast majority of their students.

DEVELOPMENTAL CHARACTERISTICS OF STUDENTS

Grades K through 3

Students are likely to be:

* egocentric;
* developing some independence from parents and gradually orienting toward peers;
* able to relate to their own bodies/ be curious about body parts;
* highly competitive and capable of unkindness to each other;
* able to understand information if it relates to their own experiences.

APPROPRIATE APPROACHES TO AIDS EDUCATION

Grades K through 3

The primary goal is to allay children's fears of AIDS and to establish a foundation for more detailed discussion of sexuality and health at 6th grade level.

* Information about AIDS should be included in the larger curriculum on body appreciation, wellness, sickness, friendships, assertiveness, family roles and different types of families.
* Children should be encouraged to feel positively about their bodies and to know their body parts and the difference between girls and boys. Teachers should answer their questions about how babies are developed and born.
* AIDS should be defined simply as a very serious disease that some adults and teenagers get. Students should be told that young children rarely get it and that they do not need to worry about playing with children whose parents have AIDS or with those few children who do have the disease.
* Children should be cautioned never to play with hypodermic syringes found on playgrounds or elsewhere and to avoid contact with other people's blood.
* Questions should be answered directly and simply; responses should be limited to questions asked.
* Children should be taught assertiveness about refusing unwanted touch by others, including family members.

DEVELOPMENTAL CHARACTERISTICS OF STUDENTS

Grades 4 and 5

Students are likely to be:

- aware of sexual feelings and desires either in themselves or in others and confused about them;
- increasingly sensitive to peer pressure;
- capable of concern for others;
- exploring sex roles;
- in different stages of pre-puberty and early puberty and usually very interested in learning about sexuality and human relationships;
- quite comfortable discussing human human sexuality;
- confused between fact and fancy (between hypothesis and reality);
- able to internalize rules and to know what is right or wrong according to those rules.

Grades 6 through 9

Students are likely to be:

- engaged in a search for identity (including sexual identity); asking "Who am I? and "Am I normal?"; very centered on self;
- influenced by peer attitudes;
- concerned about and experimenting with relationships between boys and girls;
- confused about the homosexual feelings many of them will have experienced;
- worried about the changes in their bodies;
- able to understand that behavior has consequences, but may not believe the consequences could happen to them;

APPROPRIATE APPROACHES TO AIDS EDUCATION

Grades 4 and 5

It is appropriate to use the same approach as for grades K-3 with an increased emphasis on:

- affirming that bodies have natural sexual feelings;
- helping children examine and affirm their own and their families' values.

Teachers of 4th and 5th graders should:

- continue providing basic information about human sexuality, helping children understand puberty and the changes in their bodies;
- be prepared to answer questions about AIDS and AIDS prevention.

Grades 6-12

The primary goal is to teach students to protect themselves and others from infection with the AIDS virus.

- Students should learn all of the information on Attachment B--"What Adolescents Should Know About AIDS."
- AIDS issues should be made as real as possible without overly frightening students. Movies about or classroom visits from people with AIDS have helped students in some schools overcome their denial of the disease and give AIDS a human face.
- The focus should be on healthy behaviors rather than on the medical aspects of the disease.
- Students should examine and affirm their own values.
- Students should rehearse making responsible decisions about sex, including responses to risky situations.

DEVELOPMENTAL CHARACTERISTICS OF STUDENTS

- fearful of asking questions about sex which might make them appear uninformed.

Grades 10 through 12

Students are likely to be:

- still struggling for a sense of personal identity, especially those who are confused about their sexual identities;
- thinking that they "know it all";
- seeking greater independence from parents;
- open to information provided by trusted adults;
- near end of this period, beginning to think about establishing more permanent relationships;
- experiencing an illusion of immortality;
- sexually active.

APPROPRIATE APPROACHES TO AIDS EDUCATION

- Students should know they have a right to abstain from sexual intercourse or to postpone becoming sexually active. They should be helped to develop skills to assert this right.
- It must not be assumed that all students will choose abstinence.
- Information about AIDS should be presented in the context of other sexually transmitted diseases (STDs).
- It is important to be honest and to provide information in a straightforward manner. Be explicit. Use simple, clear words. Explain in detail. Use examples.
- Sexual vocabulary should be connected with slang, if necessary, to be certain students understand the lesson.
- It is important to be non-threatening and to work to alleviate anxiety.
- Discussion of dating relationships can provide opportunities to teach decision-making skills. Students should be helped to think through how to make responsible decisions about sex before questions arise in a dating context.
- Teaching about AIDS is often enhanced by:
  -- movies and other visual aides
  -- role plays and other participatory exercises
  -- same sex groupings (to encourage more candid discussion) followed by sharing in a mixed-sex group (to increase comfort level in discussing sexual subjects with members of the opposite sex);
  -- involvement of students in planning and teaching--let young people speak the message to each other whenever possible.
- AIDS education should also include discussion of critical social issues raised by the epidemic, such as protecting the public health without endangering individual liberties.
- Teachers should have resources to help students find answers to detailed medical questions.
- Students should be taught skills that will enable them to continue to evaluate the AIDS crisis.

Attachment B: WHAT ADOLESCENTS SHOULD KNOW ABOUT AIDS

The information adolescents need is simple and straightforward. Home and school instruction should emphasize prevention through teaching safe behaviors. While adolescents need only minimal knowledge of the medical aspects of the disease, some may seek a more in-depth understanding of the virus and its manifestations. Teachers and parents should be prepared to answer their questions.

This is what should be appropriately communicated to all adolescents:

DEFINITION OF AIDS

A disease triggered by infection with the human immunodeficiency virus (HIV) which weakens the immune system causing the infected person to catch certain diseases that healthy people can fight off, but that can be fatal to a person with AIDS. Unlike most infections, HIV infection does not go away. The virus remains in the person's body for the rest of her or his life.

TRANSMISSION OF THE AIDS VIRUS

HIV is extremely difficult to catch. It is not transmitted by casual contact such as hugging, sneezing, or sharing bathrooms.

There is no danger of getting AIDS by donating blood. A few years ago, some people became infected with HIV through receiving blood transfusions. Now, however, all blood donations are screened and tested so that the blood supply is quite safe.

HIV is transmitted in three main ways:

1. through infected semen and vaginal secretions (by vaginal or anal sexual intercourse or, possibly, by oral sex);
2. through infected blood (by sharing intravenous IV drug needles or using unsterile hypodermic needles for steroids or any other purpose);
3. from an infected mother to her child either before or during childbirth and, possibly, through breast milk.

Anyone who engages in risky behaviors can become infected, regardless of gender, sexual orientation, age or race.

THREE MANIFESTATIONS OF INFECTION

1. Many people who are infected with the virus have no symptoms of disease. Since they look and feel healthy, these people may not know they are infected. They can, however, transmit the HIV to others through unprotected sexual intercourse, sharing unsterile needles, or childbirth. Many, if not all, of these carriers will eventually become symptomatic. Most of them, however, will not become sick for three to seven years or more after infection.

2. Persons who are infected with HIV may develop symptoms which are related to AIDS, but have not reached the clinical definition of AIDS. This is sometimes called AIDS Related Complex (ARC). They may be only mildly ill or very sick.

3. Manifestations of AIDS can include opportunistic infections and cancers as well as neurological and psychological problems.

TESTING

It is now possible to test blood, in most cases, to determine if a person is a carrier of HIV. At this time, the Centers for Disease Control and the U.S. Surgeon General do not recommend testing of the general population. However, men and women who are considering parenting and who practice risky behaviors are advised to be tested. Anyone thinking of being tested should contact an alternative test site which tests anonymously and offers pre- and post-test counseling. State and local public health departments can give addresses of local testing facilities.

ADOLESCENTS CAN PREVENT AIDS BY:

- abstaining from or postponing becoming sexually active;
- only having sexual relations within the context of a mutually faithful relationship with an uninfected partner;
- always using latex condoms (even in combination with other birth control) from beginning to end of all types of intercourse, preferably with a spermicidal jelly containing nonoxynol 9;
- not using intravenous drugs. Those who do should never share needles or syringes and should be encouraged to enter a drug treatment program. Those who continue to share needles should be told how to sterilize their equipment. Tattoo needles and needles used for injecting body-building hormones or for piercing ears should also never be shared.

LOCAL TELEPHONE NUMBER

Students should be given a local telephone number to call for additional information. Sources of AIDS information in other languages should also be provided. Some local AIDS hotlines have Spanish-speaking staff available during certain hours. Find out what these hours are and provide this information to Spanish-speaking students. Health clinics and other community organizations serving the Latino, Chinese and other language minority communities may also be able to provide AIDS counseling in those languages.

Attachment C: STAFF TRAINING

Staff training is a must. Two types should be provided:

I. STAFF IN-SERVICE

All staff (teachers, administrators, custodians and clerical personnel) should receive basic information about AIDS. They should understand its transmission and prevention and know where to turn in the school and in the community for more information and help.

Someone in each school should be designated as an AIDS resource person. Each school district should have a similar AIDS resource staff person at the central office level.

AIDS education at this level can be conducted as a one or two session in-service workshop. Public health departments and local AIDS service agencies can usually provide knowledgeable workshop leaders.

(continued)

II. PREPARATION FOR TEACHING AIDS PREVENTION

Training teachers to teach AIDS prevention is much more rigorous than staff in-service. Teachers and supervisory administrators who will be teaching AIDS prevention education must receive this more comprehensive training. When feasible, participants should be offered graduate level credit.

There are three components to effective training to teach AIDS prevention:

1. **Context**—Before staff are trained to teach a curriculum, a supportive context for the program must be developed within the community. A community public education campaign may be needed to help parents and other members of the community understand the importance of AIDS prevention education. This is necessary if teachers are to be free to discuss with students the many sensitive issues raised by the AIDS epidemic. See Attachment D on Parental and Community Involvement.

2. **Content**—Training should include:

   *accurate and detailed information about AIDS and a chance for participants to process this information in a way that alleviates their own fears of exposure to the virus;

   *an examination of the sensitive and controversial issues involved in AIDS prevention; staff should be helped to look at their own attitudes about sexuality and AIDS;

   *classroom strategies and activities, including models for integrating AIDS education into comprehensive units on health and family life education.

3. **Methodology**—Teachers should be trained to impart information to students in a way which personalizes the issues and helps students realize that AIDS affects them. Training should enable teachers to identify (a) specific student behaviors which they want to change and (b) skills students need to affect those behavior changes. These skills concern decision-making, effective communication, and assertiveness. Teachers should be further trained to provide a context where students can practice these skills. A good training program will give teachers practice in building the skills they in turn will teach their students.

Teachers who are uncomfortable with the subject matter should not be required to teach an AIDS unit. Their confusion and discomfort will inevitably be conveyed to their students.

Teachers who do agree to teach AIDS units should be offered opportunities to team teach or to draw on outside resource people for support and assistance.

Family planning agencies can help identify sexuality educators to lead this training. Effective training may also involve significant participation of parents and students.

(This attachment has been excerpted from training strategies developed by ETR Associates, Santa Cruz, CA.)

Attachment D: PARENTAL AND COMMUNITY INVOLVEMENT

It is important to include parents and community leaders in the development and implementation of AIDS curricula. By doing so, you will:

- educate key community members about AIDS and the risks it poses to adolescents;
- involve parents in an important way in their children's education;
- develop a curriculum which considers the ethnic and cultural roots of sexual attitudes;
- build respect and a broad validation for the curriculum;
- build a solid base of supportive community members who can speak to opposition which may arise.
- give teachers the support they need to teach sensitive material in a direct manner.

Two effective means of facilitating parent/community participation are:

I. AN AIDS EDUCATION ADVISORY COMMITTEE

Form an Advisory Committee to work with key school personnel: to design a program; to provide information to the community; and to present the program to the local School Board. The committee might include parents, religious leaders, student leaders, elected officials, and staff of community agencies. Be sure the committee reflects the true racial and ethnic diversity of the community. While it is important that all members concur on the importance of effective AIDS education, committee members should reflect a broad range of community perspectives.

While the primary mandate of the Advisory Committee is the timely implementation of an AIDS curriculum, it should also begin to lay the groundwork for a comprehensive health and sexuality education program. It is through such a comprehensive program that students can acquire the self-esteem and decision-making skills necessary to make healthy choices about AIDS and other important life issues.

II. PARENTAL COMPONENT OF THE AIDS CURRICULUM

At the same time students are taught about AIDS, parents should also be educated about the disease, its transmission and prevention. A well-planned and publicized parent information night is one method. A second effective strategy is a parent/student communication component built into the curriculum itself. Students are then empowered to be educators themselves, perhaps assisted by a study guide to use in teaching their parents. The benefits of this approach include:

- reinforcement of classroom learning;
- education of parents about AIDS;
- facilitation of a dialogue between students and parents about sexuality issues.

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CERTAIN PRACTICES OF SCHOOL-AGE YOUTH

Introduction

Very few teenagers have AIDS.[37] As about one-fifth of all people with AIDS are in their twenties, however, many are likely to have contracted HIV while teenagers. Preventing the 29 million U.S. teenagers from entering AIDS risk groups may be the most effective method of AIDS primary prevention because much of what teenagers learn and do as adolescents will affect their sexual and other risk-taking behaviors in later years. Evidence suggests that this will be a major challenge as many teenagers are now engaging in behaviors involving both sex and drugs that can transmit HIV.

School-Age Youth AIDS-Related Risk Behaviors

Risky sexual behavior is widespread among teens. According to national survey data, 78 percent of males and 63 percent of females have sex while teenagers (93). Although most teenagers do not have sex until they are age 16 or 17, in some communities the average age of first intercourse is 12 (33). For a substantial number of teens, sexual activity is not infrequent; among teens 15 years of age and older, at least one-third report having sex once a week or more (93). Of those that are sexually active, over 50 percent report having two or more partners (223) and less than half say they used any method of birth control at first intercourse (152). These behaviors have resulted in alarming rates of sexually transmitted diseases (STDs) among teens; teenagers acquire more than one-fourth of the estimated annual 20 million STD cases (222).

Teens at very high risk include the estimated 125,000 to 200,000 who become involved in prostitution each year (120) and those using intravenous drugs. One national survey indicates that 1 percent of United States high school seniors have used heroin (9). Of special concern are those living in communities where HIV is already prevalent, where there is more IV drug use, and where sexual intercourse is initiated earlier, is more frequent, is not protected by condoms, and is experienced with more partners.

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[37] As of May 2, 1988, 257 out of a total of 60,852 AIDS cases reported to CDC occurred among those age 13 to 19 (192).

The Effectiveness of Specific Educational Interventions

In response to the threat AIDS poses to young people, by March 1988, 18 states had passed legislation requiring AIDS education in schools. Information about AIDS is being disseminated in schools; 51 percent of parents report that their 10-17 year-old children have already had some AIDS instruction (53). Because AIDS education is relatively new and curricula are still being developed, however, little specific information is available regarding what is actually being taught, at what grade level, within what classes, and to how many students. Furthermore, there is virtually no information regarding how effective school-based AIDS educational programs are in changing student risk behaviors. The CDC's Center for Health Promotion and Education, Office of School Health and Special Projects has funded 15 national organizations, 15 State education agencies, and 12 local education agencies to examine AIDS education within the public schools. Changes in knowledge and attitudes, and in some cases, reported behavioral intentions and behaviors, will be monitored through the use of pre- and post-intervention surveys (see appendix B).

Until data from AIDS education evaluations are available, it is worthwhile to examine the effectiveness of sexuality education programs that often include many of the same goals as AIDS education programs; to delay sexual intercourse, to reduce the number of sexual partners, and to increase the use of methods of birth control, such as condoms. Moreover, many of the decisionmaking and communication skills that sexuality educators teach are the same skills that some AIDS educators believe should be taught to reduce the transmission of the HIV virus.

This section reviews what is known regarding: 1) current levels of adolescent AIDS-related knowledge, attitudes, and beliefs; 2) the effectiveness of AIDS interventions aimed at improving knowledge and changing attitudes; and 3) the success of sexuality education in changing sexual behaviors.

AIDS Knowledge, Attitudes, and Beliefs

Several studies have demonstrated that adolescents are quite knowledgeable about AIDS, particularly about the fact that vaginal and anal intercourse with an infected partner can transmit HIV. For example, a 1986 random telephone survey of 963 adolescents 16 to 19 years old in Massachusetts revealed that 98 percent knew that anal intercourse could transmit HIV and 92 percent knew that vaginal intercourse could transmit the virus (168). Some school-based surveys, however, suggest that there are important knowledge deficits. For example, in a 1986 survey of Connecticut secondary school students only half knew that people who shoot drugs (325/638) represented a high-risk group (89). A survey conducted one year earlier in San Francisco showed that while 92 percent (1213/1313) of the students correctly indicated that "sexual intercourse was one mode of contracting AIDS," only 60 percent (782/1303) were aware that "use of a condom during sexual intercourse may lower the risk of getting the disease" (62). Black and Hispanic adolescents were less knowledgeable about AIDS and were more likely to have misconceptions about transmission than white students (60). Most students reported wanting to learn more about AIDS, and many indicated that information about AIDS should be presented in public schools. Although more recent survey data are not available, researchers report that AIDS knowledge is likely to have improved (112).

Available data suggest that teenagers have initiated little behavioral change in response to AIDS. For example, the survey of Massachusetts adolescents conducted in 1986 revealed that of the 70 percent reporting sexual activity, only 15 percent had changed their sexual behavior because of concern about contracting AIDS, and of these, only 20 percent had implemented effective changes. Many adolescents, including those in the highest-risk subgroups of sexually active or psychoactive drug users, did not know what sexual and drug precautions are needed to prevent transmission of the virus (168). To ascertain changes in knowledge, attitudes, and use of condoms in response to the threat of AIDS, a survey was conducted among sexually active adolescents attending a university or a health maintenance organization in San Francisco in 1984/85 and again in 1985/86. Although the perception that condoms prevent STDs and the value and importance placed on avoiding STDs remained high, adolescents did not report increased use, or intentions to use condoms over the study period (107).

Effectiveness of AIDS Education in Changing Knowledge and Attitudes

Thus far, evaluations of AIDS education programs in schools have focused upon changes in knowledge and attitudes (see table 2-3 for a description of evaluations of AIDS educational interventions). Significant increases in knowledge have occurred as measured before and immediately following AIDS education programs. For example, in one study, the percentage of students knowing that using condoms during intercourse is one way to help prevent the spread of AIDS increased from 70 to 87 percent (61). In another study, AIDS-related knowledge increased markedly, and students' perceptions regarding personal risk of AIDS declined slightly following the AIDS program (136). In neither study was the impact of the educational intervention on changes in risk behaviors evaluated.

Whether educational programs will affect teens' AIDS risk behaviors is uncertain. Some evidence suggests that young people who have not been exposed to an educ'tional program overestimate both the number of cases of AIDS and the chances of getting AIDS from a single unprotected act of heterosexual intercourse (80). A 1985 survey of black and Hispanic adolescents showed that more knowledge about AIDS was associated with a lower perceived risk of contracting AIDS (60). AIDS-educated youth are probably more aware that they will not contract AIDS from casual contact with others.

Effectiveness of Sexuality Education

Lessons relevant to AIDS education can be learned from the literature regarding the effectiveness of sexuality education programs designed to reduce teen pregnancy and STDs other than AIDS, and to improve teens' sexual self-awareness and communication skills. Evidence from numerous studies indicate that sexuality education increases factual knowledge about sexuality and sexually transmitted disease but has little measurable impact upon attitudes (112). Few studies have adequately measured communication and other skills thought to be necessary to implement behavioral change, and the results of these are mixed.

One intervention, a 14-part, intensive cognitive-behavioral training course, used role playing and rehearsal to improve communication skills and attitudes compatible with lowering risk of pregnancy. At six-month followup, the 18 participants reported practicing more effective contraceptive methods and exhibited better communication skills than the control group. The evaluation of the intervention relied upon excellent measurement techniques, but its findings are limited because few students were involved in the program (160). Another study of several comprehensive sexuality courses found no impact on skills even though considerable time was devoted to teaching and practicing those skills in the courses. This study included a larger number of students but employed less valid methods of measurement than the smaller study reported above (113). The results of an intervention aimed at postponing sexual involvement among adolescents should be available in the near future (112). Investigators are evaluating an educational series designed to help adolescents resist social and peer pressures that can lead to early sexual involvement. A companion program for parents helps adults better understand the pressures experienced by adolescents and assists parents in reinforcing the information given to their children in school (96).

Sexuality education programs do not appear to have had an impact upon sexual intercourse, either initiation or subsequent frequency. Although one major national study did find that among 15 and 16 year old females, those who had previously taken a sexuality education course were somewhat more likely than those who had not to initiate sexual activity at ages 15 and 16 (127), other national surveys have not found such a relationship (224). Preliminary findings from an evaluation of at least one community-based program specifically designed to reduce teen pregnancy suggest that the program may have succeeded in that effort (205). Here, an educational campaign intended to curb high teen pregnancy rates included the involvement of parents, churches, schools, the media, and other community organizations. Pregnancy rates dropped by more than half in the rural South Carolina county where the intervention was implemented. Whether the drop can be attributed to the program is, however, uncertain. Pregnancy rates in small populations may fluctuate from year to year. Furthermore, the unique program setting limits the generalizability of results.

In general, studies suggest that sexuality education may have a modest impact upon use of birth control during the first episode of sexual intercourse, and upon ever using it, but not upon current use. In one study of high school students, students who were more knowledgeable about the probability of becoming pregnant did not report unprotected intercourse less frequently than those students who were less knowledgeable. Similarly, students who were more knowledgeable about birth control were not more likely to use it (142). None of three major studies that evaluated the effect of educational interventions upon the incidence of pregnancy found a measurable impact (127,224,49).

The results of evaluations of sexuality education are consistent with studies of other kinds of educational programs designed to improve healthy adolescent behaviors. For example, driver education increases knowledge, but does not measurably reduce automobile accidents among teenagers. Other programs targeted to adolescents, however, have been successful. For example, some anti-smoking programs for young adolescents have helped them delay or refrain from smoking, and a few drug education programs, particularly those that focused upon skills, have had some success (20,73).

There are a number of reasons why increases in knowledge from sexuality educational programs have limited impact upon behavior. First and foremost, there are many important factors other than knowledge that affect teenage sexual and contraceptive behavior. Over many years, teenagers are socialized by parents and peers and exposed to television and other media of popular culture. Their behavior is affected by a myriad of internal factors, such as physical development and sexual desires, emotional needs for affection and physical contact, ego strength, plans for the future, perceived ability to control one's own future, and attitudes toward parents and society. Other factors such as the availability of birth control may affect behavior. It is not surprising therefore, that a small amount of school-supplied information about sexuality has limited impact, especially since many programs produce only modest increases in knowledge and that knowledge may diminish with time.

Although most students know even before they take a sexuality education class that sexual intercourse can lead to pregnancy and that pregnancy can be avoided by using birth control methods, many young people do not apply their knowledge to their own behavior. As evidence that teenagers do not apply information to their personal situations, one investigator found that sexually active adolescents who could correctly answer questions about the timing of ovulation and pregnancy were not more likely to assess accurately their own probability of becoming pregnant. In fact, those that did not know whether or not they would get pregnant were more likely to use birth control (142). These findings suggest that those that are unaware of their actual risk may overestimate their risk and therefore be motivated to use birth control.

Another factor contributing to failure to use effective contraception is that sex among sexually active young people may occur infrequently and is often unplanned. Teenagers who have sex infrequently may not have yet fully accepted the fact that they are sexually active and therefore may be inhibited about seeking information on contraception (112).

Conclusions

Whether the findings from research on sexuality education can be used to guide AIDS educational interventions depends in part upon teenagers' perceptions of the burden and risk posed by AIDS. Teens may be more highly motivated to adopt preventive behaviors to prevent a life-threatening disease than to prevent pregnancy or a treatable sexually transmitted disease. If teenagers do not believe that they are personally at risk of getting AIDS, however, then they may not respond to educational efforts.

In reality, for most teenagers, the probability of having sex with someone infected with HIV is quite small, and the probability of actually contracting HIV from that person is still smaller. Because teenagers, like adults, have difficulty making decisions when probabilities are small, they may be unlikely to change their behavior when provided accurate information. Educational programs may be more effective in high-risk communities where a higher percentage of people have AIDS. In such communities, the actual risk of contracting AIDS is higher and thus represents a more serious threat to teenagers. Moreover, the teenagers are more likely to know personally someone who is HIV-infected or has AIDS and thus apply the risk and costs of contracting AIDS to their own situations. To help make the risk of AIDS more personal, information about AIDS can be presented within the context of other, more prevalent STDs, such as gonorrhea and herpes simplex, with which adolescents may have greater familiarity (61).

To be effective at reducing risk-taking behavior, AIDS education programs must do much more than simply increase knowledge. Programs that use role playing extensively to improve decisionmaking and communication skills and possibly reinforce particular norms may be effective (160). In the case of AIDS, role playing may involve students' practicing how to say "no" to sex, how to refrain from having sex when condoms are not available, how to discuss the threat of AIDS without offending their sex partners, and how to insist upon the use of condoms when having sex.

AIDS educational efforts could be integrated into much more comprehensive community-wide programs that reinforce it. In addition to involving schools, such programs can include parents, radio and television stations, newspapers, churches, youth-serving agencies, family planning agencies, and other community groups or organizations. School programs are much more likely to be effective if the norms expressed in those programs are supported and reinforced by the larger social environment. At least one study indicates that such programs do affect behavior (205). When AIDS educational programs are implemented in the schools, teachers need to be trained to communicate sensitive information. Teachers who are uncomfortable discussing sexuality and specific sexual and drug-related behaviors are not likely to be effective in facilitating frank, open discussions (62).

There is evidence from other health areas, such as smoking, indicating that when programs are implemented earlier, they may be more effective. AIDS educational programs could be implemented in elementary and middle schools, as well as in high school. As gains in knowledge and attitudes acquired through educational programs appear to decline with time, there is a need to reinforce AIDS prevention messages. As adolescents advance through the school system, new, age-appropriate messages could be introduced.

Programs may be more effective if adolescents, themselves, play a major role in the educational program and accept some responsibility for the effectiveness of the programs (41). When many student leaders openly and consistently express norms against risk-taking behavior, school-wide norms may change. Another reason to implement AIDS education programs early is that those students who are most likely to live in high-risk areas and to engage in risk-taking behaviors are also more likely to drop out of school. Nationally, about 25 percent of young people drop out of school before high school graduation (112), and the percentages are much higher in communities where AIDS is likely to be more prevalent.

In addition to school drop-outs, other high-risk adolescents may not be reached through school-based AIDS educational interventions. Teen runaways, teens engaged in prostitution, and youths in juvenile detentions programs will need to be reached through community-wide strategies. One suggested approach is to train and utilize indigenous community members and groups to serve as AIDS educational resources and as community outreach workers (62). The CDC is funding several projects to reach out-of-school youth through the National Programs for School Health Education to Prevent the Spread of AIDS (SHEPSA). For example, the National Coalition of Hispanic Health and Human Services Organizations will provide agencies serving out-of-school Hispanic youth with educational materials (see appendix B).

Shelters for the homeless may be an important site for AIDS educational activities as many of them serve the estimated 1 to 1.25 million minors that annually run away from home. Characteristics of runaway and homeless youth vary in different locals but many appear to be at high risk for AIDS. One New York City-based study found 85 percent to be sexually active, 10 percent engaged in prostitution, and 5 percent using IV drugs. Anecdotal data from Los Angeles suggest that as many as 35 percent of runaway youth there have been thrown out of their homes because of homosexuality (200). AIDS information for street youth and incarcerated juveniles must be simple, explicit, and direct. As many of these youth are learning disabled or have other problems with reading, verbal educational approaches are preferable (153). The National Institute of Mental Health is funding evaluations of AIDS prevention activities implemented for adolescents who seek services at runaway shelters or at agencies serving homosexual youth (see appendix B).

DEALING WITH CONTROVERSY: THE SCHOOL BOARD PERSPECTIVE

(Presentation by Brenda Z. Greene, Manager, AIDS Education, National School Boards Association at the National Meeting on School Health Education to Prevent the Spread of AIDS, Office of School Health and Special Projects, Centers for Disease Control, February 1, 1988, Arlington, Virginia.)

School board members are not strangers to controversy. Ask any board member about the last time the board tried to close a school, change school attendance boundaries, or eliminate Friday night football. And if you think those issues are inconsequential next to the life and death and civil rights implications of AIDS, consider that school boards were dealing with such vital issues before AIDS came on the scene: school bus accidents; bomb scares; employees accused of child abuse; hostage incidents; and more recently, the threat to health of asbestos, radon, lead in drinking water--and even the toxic effects of rubber cement.

When it comes to dealing with what parents (or others) consider the "well-being of their children,"--and particularly when morals, religion, and sex are involved--there always are lots of opinions, demands, and media attention. The issue at hand can easily get out of a school board's or superintendent's control.

Never forget, it takes just one person to stir the pot of controversy--whether through letters to the editor published in the local newspaper--the best free advertising for a cause I can think of, voicing opposition at a public meeting, handing out leaflets--in general, doing something "newsworthy," that gets covered, and perhaps blown out of proportion by the local media.

For school officials, AIDS is potentially controversial for two reasons:

- First, as it involves contact with people who are infected;
- Second, as it involves what, how, and when we teach children about AIDS.

The former stems from people's ignorance, fear, and lack of trust. The latter stems from the ongoing debate over the role of schools regarding topics that traditionally have been considered the responsibility of family and perhaps religious institutions.

At NSBA, we don't believe there are any foolproof ways for school boards--or any public officials--to avoid controversy. But we do believe that controversy can be managed if it is anticipated and planned for. While the issues surrounding AIDS may pose a greater challenge than some other issues, planning ahead should help. But how do you begin?

You begin by making sure the school district has policies and procedures in place for guiding its actions. And I don't mean only policies related to how people with AIDS will be treated, though that's an important part. I mean an entire framework of policy that enables a school district to manage issues and make informed decisions that have broad-based support.

Let's look at the potential for controversy surrounding AIDS education for youth and how a comprehensive policy foundation can guide actions to manage or minimize controversy.

Say a school district is under pressure from the local health department, some parents and teachers, or the state education department to teach children about AIDS. Board members know that a lot of parents won't like the idea--and the board will hear from them--loudly.

Then say that school board elections are coming up in a few months: Board members start to think, "Why give a platform to the opposition?" The thought of teaching children about AIDS, because it is so closely tied to talk of "sex" and even homosexuality and condoms, sends shivers down the spines of most board members.

Given this scenario, the easiest path to take is----what?

Some school boards--hopefully, not too many--might duck the issue. "It's not the school's responsibility." "Our kids are safe; We don't even have anybody with AIDS in our community." "If the health department thinks it's so important, let them do it."

Other school boards have policies in place, however, that encourage school board leadership and enable the school district to address all issues--even the sensitive ones--out in the open. These school boards are not afraid to accept the challenge.

These policies encourage all interested people to become informed about and involved in the decision-making process. These policies guide the work of staff. They also ensure that board members understand and accept their responsibilities, and develop their leadership skills. Together, these policies build a layer of trust between schools and community.

Let's look at some of the policy areas that relate to managing controvery surrounding AIDS education for youth.

First, policies that support a public information program. This area targets three important audiences: news media, employees, and the community. All need to be kept fully informed. Perceptions that the school district is trying to put something over on people must be avoided at all costs. And you can't just turn your public information program on and off. It needs to be ongoing and consistent to build a solid layer of trust between a school district and its publics.

An effective public information program provides reliable answers to questions and also anticipates people's need for information. Some of the tools are publicizing board meeting agendas and providing meeting summaries, newsletters, television programs, and getting out and talking with PTAs and other community groups. An effective public information program also manages the media by paying attention to reporters' needs for accurate and complete information about the issue--and also on how decisions are made.

But being informed is not enough when managing controversy. The second policy area that needs to be in order supports involvement in decisionmaking. Whether people are informed before or after the fact, they will have opinions to express. If they can express them before decisons are made, and if they truly believe their views have been heard and considered, their complaints--if they persist, will have less merit. More often than not, involvement will build broad-based support.

Who should be involved?

All those who will be affected by the decision or who have a vested or sincere interest in the decision. For the subject of AIDS education, that probably means parents, teachers, principals, curriculum developers, the clergy, medical authorities, and students, as well as organizations such as PTA and others that traditionally have taken an active interest in local school affairs and the welfare of children.

People can be involved in decisionmaking in a variety of ways--all of them grounded in school board policies. For example, where minimal controversy is anticipated, simply being able to testify publicly at a board meeting or public hearing may be adequate. School boards are advised to have in place policies that formalize the procedures for public participation at board meetings because the businesslike atmosphere of the meeting cannot be allowed to disintegrate into a free-for-all.

For AIDS education, however, it is probably wise to plan for more than the minimum level of involvement. Rather, getting people involved at the earliest stages will be important. Policies that set forth guidelines for advisory committees to the board and to staff, for example, are designed to elicit diverse points of view early on, to confront differences of opinion and recognize shared views, to identify common goals, to negotiate comprises, and to reach consensus on a proposal.

Well-designed advisory committees--and that means including as many diverse views as possible--result in three major benefits: Advisory committee members serve as conduits of information to the larger community, thus broadening understanding and support; the committee process ensures that community values are truly reflected; the school board is provided with a body of information--recommendations, rationales, pros and cons on given issues, that it can use in responding with consistency to critics.

Some people think advisory committees slow down the decision-making process. That's true. The alternative, however, is to get bogged down at the end of the process when people who disagree with the proposal complain.

AIDS education is ripe with potential conflicts that can be negotiated early on. For example, at what grade levels will various elements of the curriculum be taught? Just what will be included in the curriculum--this is the time to debate to what extent, if at all, use of condoms will be discussed? Will the terms anal, oral, and vaginal intercourse be used? Who will teach children about AIDS?

Other policy areas that relate to decisions about AIDS education are:

Curriculum development and adoption--policy that assures that staff will not just pick a curriculum based on its promotional literature. Rather, it encourages and enables staff to do necessary research about the subject, consult with experts, gather samples from publishers and other districts and acknowledges that the board formally adopts curriculum.

Complaints about curriculum, instructional materials, staff--policies that provide an orderly process for review of complaints.

Evaluation--policy that provides for periodic reports to the board on how well objectives are being met and what revisions, if any, would be useful.

There's another policy area that shouldn't be neglected. That's school board and staff development, particularly making sure that school district leaders have the necessary knowledge about the subject and, as important, the communication skills for dealing with the public. Savvy politicians know how to control their answers to reporters' questions; school board members and superintendents need to learn--and practice--these skills.

Finally, it is critical that board members understand their powers and duties--that only the board as a body makes decisions, not individual members--and that once a decision is made, all board members--and the superintendent--will support it.

CHURCHES CALL FOR EDUCATION ON AIDS

(Church statements collected by the National Council of the Churches of Christ, New York, N.Y., February 1988.)

General Convention of the Episcopal Church (1985)

Resolution calling for the development and funding of programs of awareness, education and prevention concerning AIDS.

The American Friends Service Committee (1987)

Educational strategies must provide accurate, explicit, comprehensible and compelling information about "safe sex" practices, the risks of promiscuity and the dangers to drug abusers from contaminated needles. Special efforts will be needed to reach those communities that are particularly vulnerable and poorly served by information and health care systems.

The General Board of Global Ministries, United Methodist Church (1986)

BELIEVES that the health of a society is jeopardized through panic, the propagation of fear and unfounded information about diseases and their transmissions; RECOGNIZES the critical need for balanced, accurate, scientifically sound and understandable information about AIDS and how to prevent it through health-promoting behavior and health education; and CHALLENGES the scientific, public health, communications and religious communities to take leadership in this regard.

Presbyterian General Assembly (1986)

Calls upon Presbyterians to work within the various educational systems in churches and communities to provide accurate, current AIDS information to diffuse the unfounded fears created by ignorance or false information.

United States Catholic Conference (1987)

We are convinced the only measures that will effectively prevent this disease at present are those designed to educate and to change behavior. ...We will support legislation and educational programs that seek to provide accurate information about AIDS... As members of the Church, we must offer a clear presentation of Catholic moral teaching with respect to human intimacy and sexuality.

Lutherans

Challenge the Church to make public discussion happen that faces up to the political, social, economic, health, religious, and ethical issues at every level of human interaction including the church, school, and government.

United Church of Christ (1987)

Members and congregation...to become knowledgeable about AIDS and become leaders in mobilization of compassionate ministries, effective public policy, and preventive education in their communities, in the nation, and in the global community.

American Baptist Churches (1987)

Commends our churches and colleagues in ministry who seek to educate people about the disease, reducing the fear and prejudice against those with AIDS....

1 of 2

PUBLISHED DENOMINATIONAL STATEMENTS

(Compiled by National Council of the Churches of Christ in the USA, 2/88)

American Baptist
Statement on Ministry to Persons with AIDS, Ministers Council, American Baptist Churches in the USA, 7/87. (Ministry Council, ABC-USA, P.O. Box 851, Valley Forge, PA 19482-0851)

Catholic
The Many Faces of AIDS: A Gospel Response, Administrative Board, U.S. Catholic Conference, 11/87. (Office of Publishing and Promotion Services #195-4, U.S. Catholic Conference, 1312 Massachusetts Ave., N.W., Washington, DC 20005-4105)

Church of the Brethren
A Call to Compassion: Church of the Brethren Statements on AIDS, Annual Conference, 1987. (Brethren H & W Assn. Comm., 1451 Dundee Ave., Elgin, IL 60120)

Episcopal
Resolution regarding AIDS, General Convention of the Episcopal Church, 1985. (Episcopal Church Center, 815 Second Ave., New York, NY 10017)

Friends
AIDS: Public Health and Public Policy, G-17, 11/87. (FCNL, 245 Second St., N.E., Washington, DC 20002)
The AIDS Crisis: Education and Policy Issues, AFSC Board of Directors, 9/26/87. (Information Services Dept., American Friends Service Committee, 1501 Cherry St., Philadelphia, PA 19102)

Lutheran
AIDS: A Challenge to the Church: A Serious and Special Opportunity for Ministry, Division for Service and Mission in America, American Lutheran Church, Mission Discoveries Reports 9 & 12, March 1986 and July 1987. (ELCA, 8765 W. Higgins, Chicago, IL 60631)

Methodist
Statement on the Church as a Healing Community and the AIDS Crisis, General Board of Global Ministries of the United Methodist Church, 4/11/86; AIDS and the Healing Ministry of the Church, A Resolution for the 1988 General Conference of the United Methodist Church. (Service Center, General Board of Global Ministries, 7820 Reading Road, Caller No. 1800, Cincinnati, OH 45222-1800)

National Council of the Churches of Christ in the USA
A Resolution on the Churches' Response to the AIDS Crisis, Governing Board, 5/86. (NCCC AIDS Task Force, Division of Church and Society, Room 572, 475 Riverside Dr., New York, NY 10115)

Presbyterian
Resolution on Acquired Immune Deficiency Syndrome (AIDS), Presbyterian Church General Assembly, 1986. (Stated Clerk, PC -- USA, 100 Witherspoon St., Louisville, KY 40202)

SECTION 6: PARTICIPANT NOTEBOOK

HOW TO USE THE MASTER COPY OF YOUR PARTICIPANT NOTEBOOK

The following pages, printed in black on white stock, form a permanent, master copy of the participant notebook to be distributed to each board member who attends your session. To reproduce, simply line up the blue line on these pages with the margin indicated on your printer. Include the cover sheet so the packet is clearly labeled. When the job is done, replace the originals in this binder.

Also included in this section are master copies of some workshop exercises that can be provided participants in a "take-home" packet for use in their school communities. A sample cover letter also is provided.

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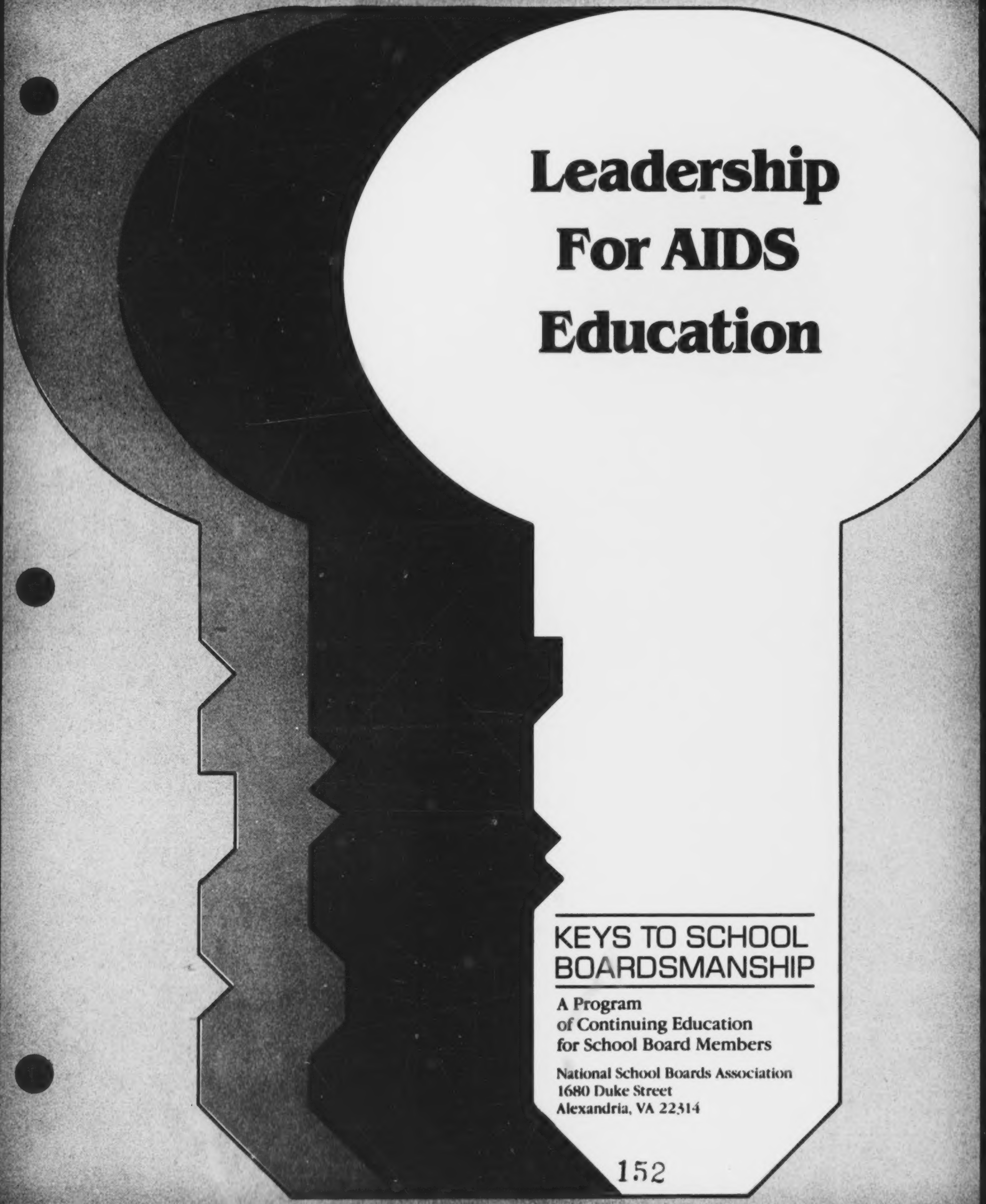

Leadership For AIDS Education

KEYS TO SCHOOL BOARDSMANSHIP

A Program
of Continuing Education
for School Board Members

National School Boards Association
1680 Duke Street
Alexandria, VA 22314

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ABOUT LEADERSHIP FOR AIDS EDUCATION

This continuing education program for school board members was developed by the National School Boards Association (NSBA) in cooperation with Division of Adolescent and School Health, Center for Chronic Disease Prevention and Health Promotion, of the Centers for Disease Control (CDC). It is designed to assist local school board members in taking a leadership role in the battle against the epidemic of HIV (human immunodeficiency virus) infection by providing school-based education for youth.

NSBA was one of the first 19 national organizations awarded cooperative agreements by the CDC in an effort to provide effective HIV education to youth. In addition, HIV education projects of all state education agencies and 16 local school districts were funded by CDC in the first year of this national project.

Contained in this notebook are:

- information about HIV infection, AIDS, which is the final stage in the continuum of conditions resulting from HIV infection, and HIV prevention education;
- knowledge, attitude, and skill-development activities for board members; and
- information on available resources that will be useful to local districts in developing effective HIV education programs within their communities.

ABOUT THE NATIONAL SCHOOL BOARDS ASSOCIATION

The National School Boards Association (NSBA) is a not-for-profit organization whose primary mission is the advancement of education through the unique North American system of representative and participatory government, whereby elementary and secondary school policy is decided by local school board members who are directly accountable to the community. NSBA promotes the quality of education through a variety of services to state school boards associations and local school districts. It represents school boards' interests in Washington, D.C., before Congress, federal education agencies, and other national regulatory bodies.

Federation members of NSBA include the 49 state school boards associations and the boards of education of Hawaii, the District of Columbia, and the U.S. Virgin Islands. Founded in 1940, NSBA represents approximately 97,000 of the nation's school board members, who, in turn, represent the more than 40 million public school children in the U.S., which accounty for about 90 percent of all elementary and secondary school students in the nation.

WORKSHOP GOAL

TO PROVIDE SCHOOL BOARD MEMBERS WITH THE INFORMATION AND SKILLS NEEDED TO PROVIDE LEADERSHIP FOR HIV EDUCATION IN SCHOOLS

OBJECTIVES

- CONVEY IMPORTANCE OF EDUCATION TO PREVENT SPREAD OF HIV
- CLARIFY SCHOOL ROLE AND RESPONSIBILITY FOR HIV EDUCATION
- PROVIDE A PROCESS FOR DEVELOPING AND IMPLEMENTING HIV EDUCATION
- ENHANCE FOR MANAGING CONTROVERSY SURROUNDING HIV EDUCATION
- PROVIDE ACCESS TO RESOURCES FOR DEVELOPING AND IMPLEMENTING HIV EDUCATION

HIV PRETEST: WHAT DO YOU KNOW ABOUT HIV AND AIDS?

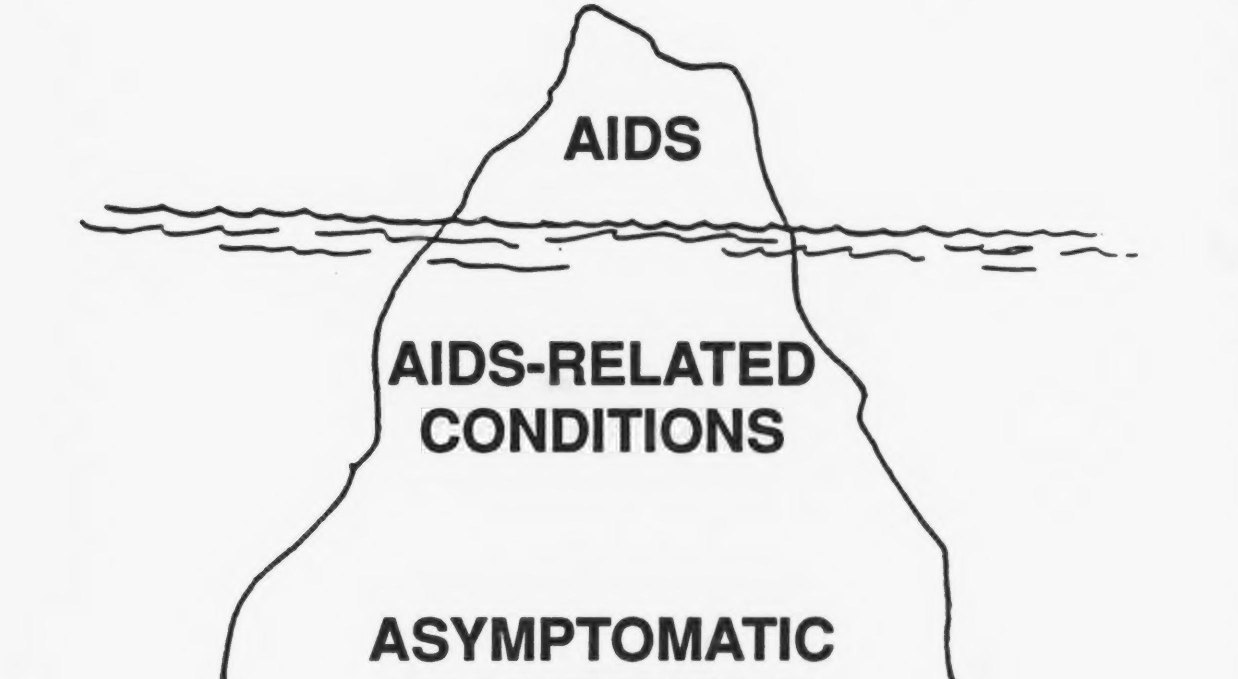
For each statement, circle the answer that you believe is most correct:
T = True F = False D = Don't know U = Undecided

1. The AIDS virus, HIV (human immunodeficiency virus), can cripple the body's immune system by destroying certain white blood cells. T F D U
2. There is no known cure or vaccine for HIV infection. T F D U
3. HIV can be transmitted by an infected person who has no symptoms of disease. T F D U
4. HIV is transmitted through vaginal, anal, or oral sexual contact, through direct blood-to-blood exchange such as through sharing of needles, or from an infected woman to child during pregnancy, childbirth, or breastfeeding. T F D U
5. Infection with HIV is usually diagnosed through blood tests for antibodies to the virus. T F D U
6. HIV does not survive long in the open air. T F D U
7. HIV is not transmitted through casual contact such as shaking hands, sneezing, coughing, insect bites, or eating foods prepared by an infected person. T F D U
8. By February 1989, more than 85,000 persons in the United States had been diagnosed for AIDS, of which 57 percent had died. T F D U
9. The Centers for Disease Control estimates that 1 to 1.5 million people in the U.S. are infected with HIV. T F D U
10. Education about how to prevent infection with HIV by avoiding high-risk behaviors is a critically important means of stopping the HIV epidemic. T F D U
11. Youth are at high risk of being infected with HIV if they are engaging in sexual intercourse or sharing needles to use drugs. T F D U
12. The most accessible sources of reliable information about HIV are local and state health departments, and local, state, and national AIDS telephone hotlines. T F D U

Fill in the blank

_________ cases of clinically diagonosed AIDS have been reported in this state.

CLINICAL SPECTRUM OF HIV INFECTION "ICEBERG MODEL"



AIDS

AIDS-RELATED CONDITIONS

ASYMPTOMATIC HIV INFECTION

DON'T BELIEVE EVERYTHING YOU HEAR OR READ ABOUT AIDS

People get information about HIV infection and AIDS from a variety of sources. Daily newspapers and television and radio newscasts provide varying amounts and quality of information. For health-related information, many people rely on "supermarket medical journals" whose headlines proclaim instant remedies or dire threats.

How do you know whether information on HIV infection and AIDS is authoritative and reliable? This is a common and important question, especially when the media relay conflicting information.

First, keep in mind that preliminary news reports may not be based on careful scientific review of all available information. In other words, the headlines do not tell the full story. Generating a consensus of the medical community takes time and effort. The Centers for Disease Control (CDC) is a credible and respected authority on HIV: CDC epidemiologists have tracked the virus since it first appeared in the United States, and the agency is responsible for the national clearinghouse for information on the epidemic. Most authorities agree that studies and information appearing in CDC publications are scientific and reliable. To evaluate studies or information from other sources, consider these questions:

- Does your local or state health department confirm the information?
- Has the study been published in a scientific journal after being subjected to peer review?
- How large a study is it, and how narrow or broad are the implications?
- Has the research been duplicated?
- If coming from the news media, has the information been appraised adequately?

Also consider that, although much is being learned about the scope of the HIV epidemic, the progression of HIV infection, and how resulting opportunistic diseases can be treated, a growing body of evidence confirms how HIV is (and is not) transmitted: through sexual intercourse with an infected person; through exchange of infected blood, most often through intravenous drug use; and from woman to child during pregnancy, childbirth, or breastfeeding.

HOW MANY PEOPLE HAVE AIDS?

Acquired immunodeficiency syndrome (AIDS) is diagnosed by physicians when certain conditions are present in a person infected with the human immunodeficiency virus (HIV). These cases are reported to state health departments and to the Centers for Disease Control (CDC).

The CDC publishes HIV/AIDS Surveillance, a monthly report that replaced the previously published AIDS Weekly Surveillance Report early in 1989. These reports have included data on:

- Cases and annual incidence rates (per 100,000) for states and large metropolitan areas;
- Cases according to transmission category, age group, sex, and race/ethnicity;
- Deaths and case fatality rates by half-year of diagnosis and age group;
- Cases by year of diagnosis and definition category.

State health departments also publish periodic surveillance reports. Neither the CDC nor the state reports include cases of ARC (AIDS-related complex), a poorly defined condition in which various symptoms of HIV infection may be present; neither do they report asymptomatic cases of HIV infection, although at least six states require such reporting. The CDC estimates that 1 to 1.5 million U.S. residents are infected with HIV.

Through January 1989, the CDC had been notified that 85,226 persons (including Guam, Puerto Rico, U.S. Virgin Islands, and Pacific Islands, Trust Territory) had been clinically diagnosed for AIDS. Of these, 57.4 percent of adults/adolescents (48,102 persons) and 55 percent of children under age 13 at time of reporting (768 children) had died. The CDC projects that by the end of 1992 there will have been 365,000 cases of AIDS and that the cumulative death count will reach 263,000, or 72 percent of the predicted case total.

TRANSITIONAL STATE: EXPERIENCING LOSS

In the space below, list:

1. A material possession you value dearly.

2. A personal or physical attribute of which you are proud.

3. Your favorite physical activity.

4. A personal secret that you share with few people or with no one (draw a circle around the secret to signal it is "hidden").

5. A friend or loved one whose support has been critical to you.

TRI-LEVEL APPROACH TO HIV EDUCATION TO PREVENT INFECTION WITH HIV

SCHOOLS SHOULD PROVIDE EDUCATION THAT IS DESIGNED TO ADDRESS THE RANGE OF BEHAVIORS OCCURRING AMONG STUDENTS

EDUCATION THAT ENABLES AND ENCOURAGES STUDENTS TO:

1. ABSTAIN FROM SEXUAL INTERCOURSE
2. ABSTAIN FROM DRUGS.

EDUCATION THAT ENABLES AND ENCOURAGES STUDENTS TO:

1. STOP HAVING SEXUAL INTERCOURSE UNTIL THEY ARE READY TO ESTABLISH A MUTUALLY MONOGAMOUS RELATIONSHIP
2. STOP USING OR INJECTING ILLICIT DRUGS.

EDUCATION THAT ENABLES AND ENCOURAGES STUDENTS WHO ENGAGE IN RISKY BEHAVIORS TO:

1. AVOID SEXUAL INTERCOURSE WITH ANYONE INFECTED, AT RISK OF BEING INFECTED,OR WHOSE INFECTION STATUS IS NOT KNOWN
2. USE LATEX CONDOMS WITH SPERMICIDE WHEN ENGAGING IN SEXUAL INTERCOURSE
3. SEEK TREATMENT FOR DRUG ADDICTION
4. NOT SHARE NEEDLES OR OTHER INJECTION EQUIPMENT
5. SEEK COUNSELING AND TESTING IF HIV INFECTION IS SUSPECTED.

Based on Guidelines for Effective School Health Education to Prevent the Spread of AIDS, Centers for Disease Control, 1988.

INDICATORS OF YOUTH AT RISK OF HIV INFECTION

- SEXUAL ACTIVITY
    - Teen Pregnancies
    - Sexually Transmitted Diseases (STDs) Among Teens
    - Contraceptive Use by Teens
- ILLICIT DRUG USE
    - School Disciplinary Actions
    - Enrollment in Treatment Programs
    - Arrests
    - Deaths Resulting from Drug Use
- SOURCES OF INFORMATION
    - Public Health Agencies
    - Social Service Agenices
    - Hospitals and Medical Associations
    - Nonprofit Organizations (e.g., American Red Cross, Planned Parenthood)
    - School Disciplinary Records
    - Arrest Records
    - Clergy
    - Other? ______________________________

SPHERES OF INFLUENCE ON STUDENTS

PROGRAM COMPONENTS THAT SUPPORT AIDS INSTRUCTION

Healthful School Environment

Administrators and Coordination

Instructional Program

Student Involvement Programs

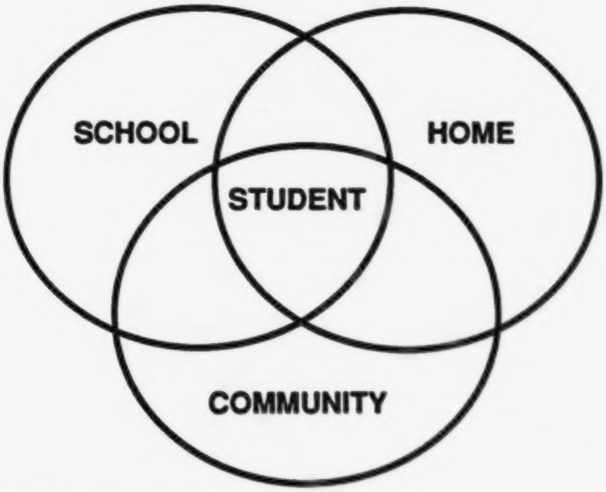
Supportive School Health Services

Supportive Home Environments

School-Community Sponsored Programs for Families

Educational Support

Parent Involvement in School Programs



Community Programs

Educational Support

Coordination Among Agencies

WHOSE RESPONSIBILITY?

Schools often are called on to solve "society's" problems. Sometimes the school's responsibility for dealing with a social issue is clear. At other times, it may be more appropriate for another sector of society to bear the primary responsibility, with schools providing appropriate support.

For the following AIDS-related tasks, designate which sector should have the primary responsibility and what, if any, the role of schools should be.

Use the following key: S = Schools F = Family C = Community
(Note: Community includes health care providers, church, nonprofit organizations, business community, and media. When your answer is "C," indicate which of these has the primary responsibility.)

Task	Schools	Family	Community
Relieving children's fears about AIDS	S	F	C ____________
School role ________________________________			
Teaching youth about prevention of HIV infection	S	F	C ____________
School role ________________________________			
Training AIDS educators	S	F	C ____________
School role ________________________________			
Teaching adults about prevention of HIV infection	S	F	C ____________
School role ________________________________			
Referring youths at risk to appropriate service providers	S	F	C ____________
School role ________________________________			
Distributing latex condoms	S	F	C ____________
School role ________________________________			
Testing for HIV antibodies	S	F	C ____________
School role ________________________________			
Determining HIV-related knowledge, attitudes, and behaviors among youth	S	F	C ____________
School role ________________________________			
Collecting local data on HIV infection	S	F	C ____________
School role ________________________________			

RESOURCES IN MY COMMUNITY THAT SHOULD BE INVOLVED

When you return home, use this outline to identify, by name, those agencies, organizations, and individuals that should be involved in developing or providing HIV education and related services for youth. These might range from the public health department (specific office) to individual community leaders and parents.

Medical Professionals (e.g., public health department, hospitals, medical society)

School Personnel/Departments (e.g., curriculum developers, guidance counselors, school nurses)

Youth-Oriented Organizations (e.g., Boy Scouts and Girl Scouts, youth recreation centers)

Substance Abuse Prevention Agencies (e.g., treatment centers)

Nonprofit Organizations (e.g., American Red Cross, Planned Parenthood)

Religious Institutions and Related Organizations (e.g., specific churches and individuals, alliances of local clergy)

School and Civic organizations and Community Leaders (e.g., PTA, League of Women Voters, individual parents)

Family Service Organizations (e.g., social service agencies, individual family and adolescent counselors)

Other

SETTING CRITERIA FOR HIV EDUCATION

Read the following statements. For each statement, circle either Yes (Y) or No (N). In the space provided, briefly note the reason for your response.

		Yes	No
1.	HIV instruction should be geared to the chronological and developmental age of children.	Y	N
2.	The content of the curriculum should be based on information from reliable medical sources and delivered in specific terms that children understand.	Y	N
3.	To effectively teach children about AIDS and HIV infection, a teacher needs nothing but accurate information on the subject.	Y	N
4.	HIV education may be most effective when integrated into a comprehensive K-12 health education program that focuses on promoting good health, self-esteem, and decision-making skills.	Y	N
5.	The best time to teach children the specific ways to avoid infection with HIV is before they become sexually active or begin using illicit drugs.	Y	N
6.	Parents should have an opportunity to review the curriculum and instructional materials before their children receive instruction about HIV infection.	Y	N
7.	The curriculum should focus on the biological aspects of the disease.	Y	N
8.	The curriculum should include information for students on where to obtain additional information.	Y	N
9.	The most important fact students should learn about HIV infection is that it can be prevented by avoiding risky behaviors.	Y	N
10.	Only certified health education teachers need training for teaching about HIV infection.	Y	N

CRITERIA FOR AN HIV CURRICULUM

CONTENT

* Information in clear terms

* Teach healthy behaviors

* Teach that anyone can get HIV infection

* Multiple learning opportunities

DEVELOPMENT AND IMPLEMENTATION

* Teacher involvement

* Teacher training

* Attention to special needs students

* Curriculum regularly updated

* Parent and community participation

* Ongoing dialogue and evaluation

CONSIDERATIONS WHEN DESIGNING YOUR HIV EDUCATION PROGRAM

(Based on materials from AIDS Handbook, Kansas Association of School Boards, Inc., 1987)

- What age group will be taught?
- Where will the instruction take place (sex education classes, physical education classes, health education classes, other)?
- Will instruction be in large or small groups?
- Which teachers will have responsibility for instruction?
- Will outside speakers participate?
- Will schools have a contact person to whom students can go with questions about the disease after they receive HIV instruction?
- Will parents be allowed to excuse their children from instruction?
- What kind of HIV education will be offered for parents and other members of the community?
- Will the students need HIV instruction for graduation?
- Who will develop the curriculum?
- Will HIV instruction include discussion of the legal and ethical issues the disease raises?

School boards should:

- Seek advice from public health departments and medical experts before developing a curriculum.
- Allow time for public review of materials.
- Provide training in HIV instruction to school staff, with the help of local public health officials.

Staff training:

- Appropriate training of all staff is a must.
- Train teachers, administrators, and auxiliary staff.
- Do as much training as possible.
- Offer the training as a college credit or inservice credit.
- Training should:
    - -- help staff examine their own attitudes about sexuality and HIV infection;
    - -- provide accurate information about HIV infection; and
    - -- provide skills to implement an HIV curriculum.

EVALUATING HIV CURRICULUM MATERIALS

(Based on materials from AIDS Handbook, Kansas Association of School Boards, Inc., 1987 and Criteria for Evaluating an AIDS Curriculum, National Coalition of Advocates for Students, 1988)

Curriculum Content:

- Does the curriculum give simple, clear, and direct information? Is that information given in terms, including slang, that students understand?
- Does the curriculum focus on teaching healthy behaviors or just on the biological aspects of the disease?
- Is there emphasis upon high-risk behavior so that the message is clear that anyone can be infected with HIV, regardless of race, sex, age, or sexual orientation.
- Are multiple class periods provided to give each student multiple opportunities to learn to make decisions based on the information they learned about HIV infection?

Development and Implementation:

- Is the district providing adequate and ongoing training to those who teach the curriculum?
- Is the district taking into account students who have limited proficiency in English, the hearing-impaired and visually impaired, and those students who are severely disabled?
- Is there a process in place for evaluating the curriculum and for updating it regularly to incorporate new information as it becomes available?
- Has the curriculum been developed with the participation and support of teachers, administrators, parents, students, and other community groups?
- Is an ongoing dialogue being conducted with parents, students, and others on these issues?

HIV Education Content Areas:

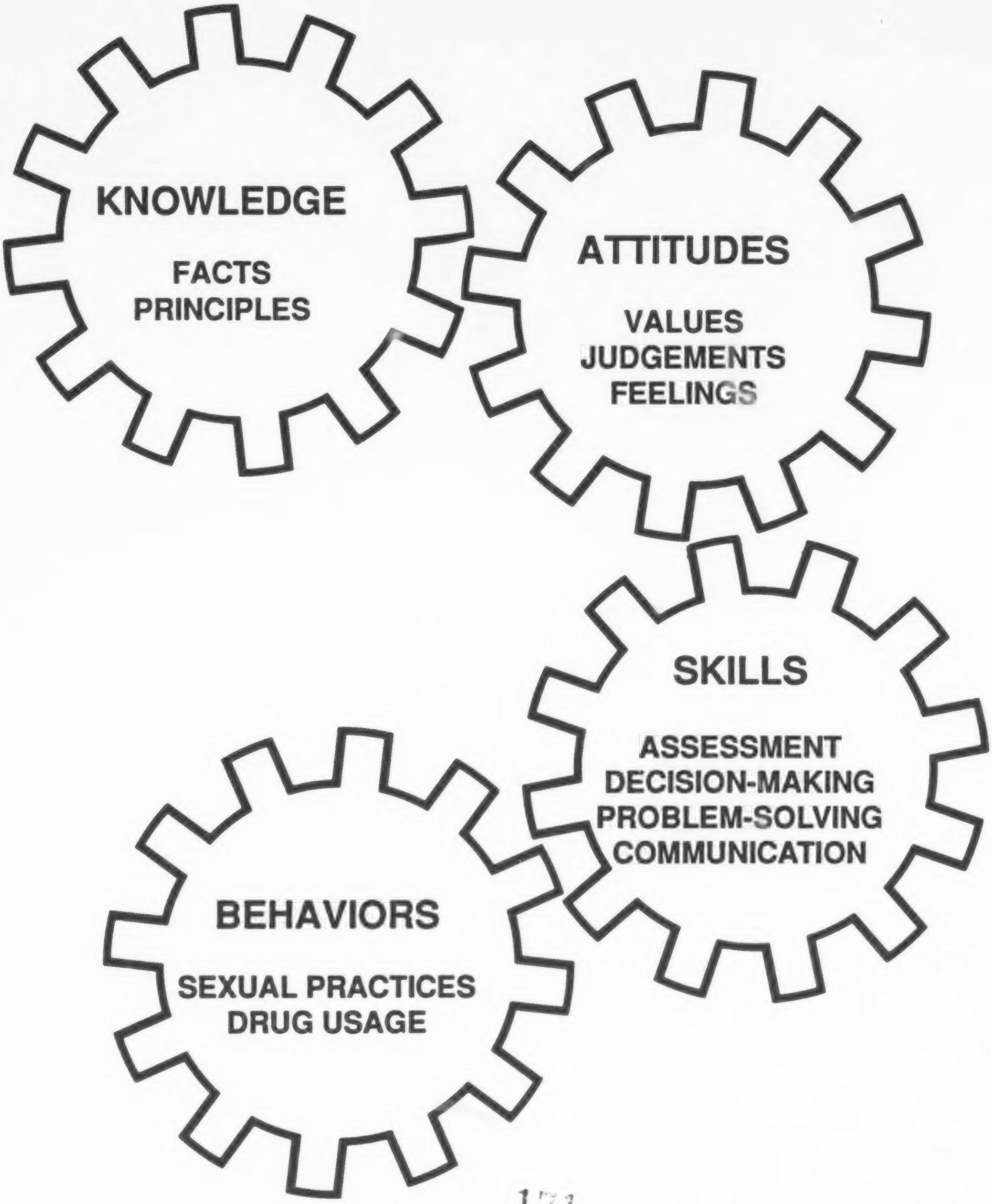
- Social Studies--epidemics and their history; culture and its role in family life and socialization.
- Civics--community and political responsibilities: public policy; the economics of the disease.
- Science--microbiology; pathology; infection; transmission of viruses; preventive medicine.
- Mathematics--patterns of epidemiology; costs of care.

(continued)

EVALUATING HIV CURRICULUM MATERIALS (continued)

- Language Arts--effective communication; evaluation of media messages; cultural terminology; definition of terms.
- Home and Career Skills--family life education; child development; health careers; consumer education.
- Library/Media--access, use, and comprehension of current events in newspapers, books, magazines, films, and videos related to AIDS.
- Multidisciplinary Approach--reinforces information; strengthens concepts, content, and teaching; establishes a teacher network.

FOUR INDIVIDUAL ELEMENTS INTERACT TO SUPPORT ALL BEHAVIOR



KNOWLEDGE

FACTS
PRINCIPLES

ATTITUDES

VALUES
JUDGEMENTS
FEELINGS

SKILLS

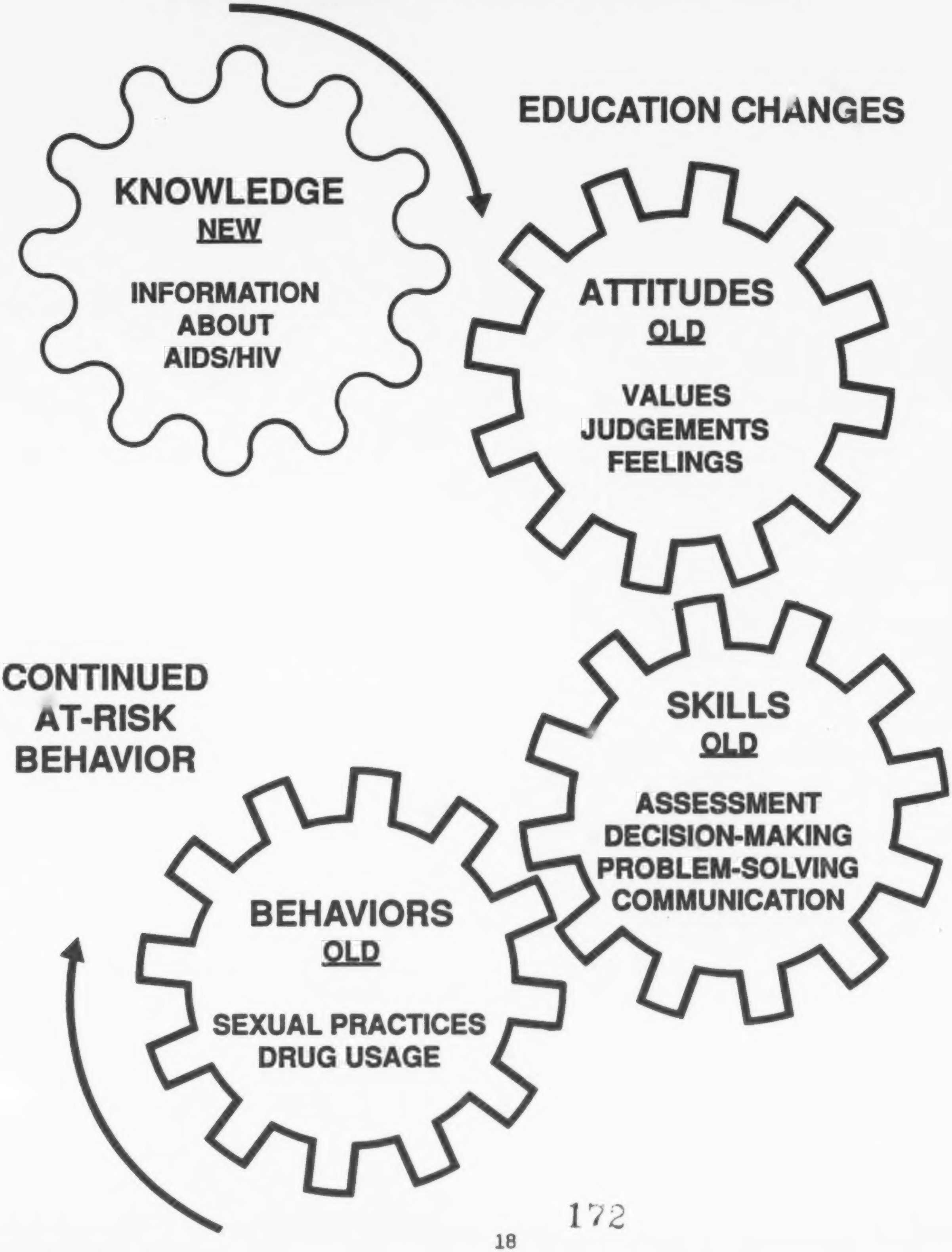
ASSESSMENT
DECISION-MAKING
PROBLEM-SOLVING
COMMUNICATION

BEHAVIORS

SEXUAL PRACTICES
DRUG USAGE

PREVENTION IS MORE THAN CONVEYING INFORMATION

(OR HOW NOT TO TEACH ABOUT AIDS)



EDUCATION CHANGES

KNOWLEDGE
NEW

INFORMATION
ABOUT
AIDS/HIV

ATTITUDES
OLD

VALUES
JUDGEMENTS
FEELINGS

SKILLS
OLD

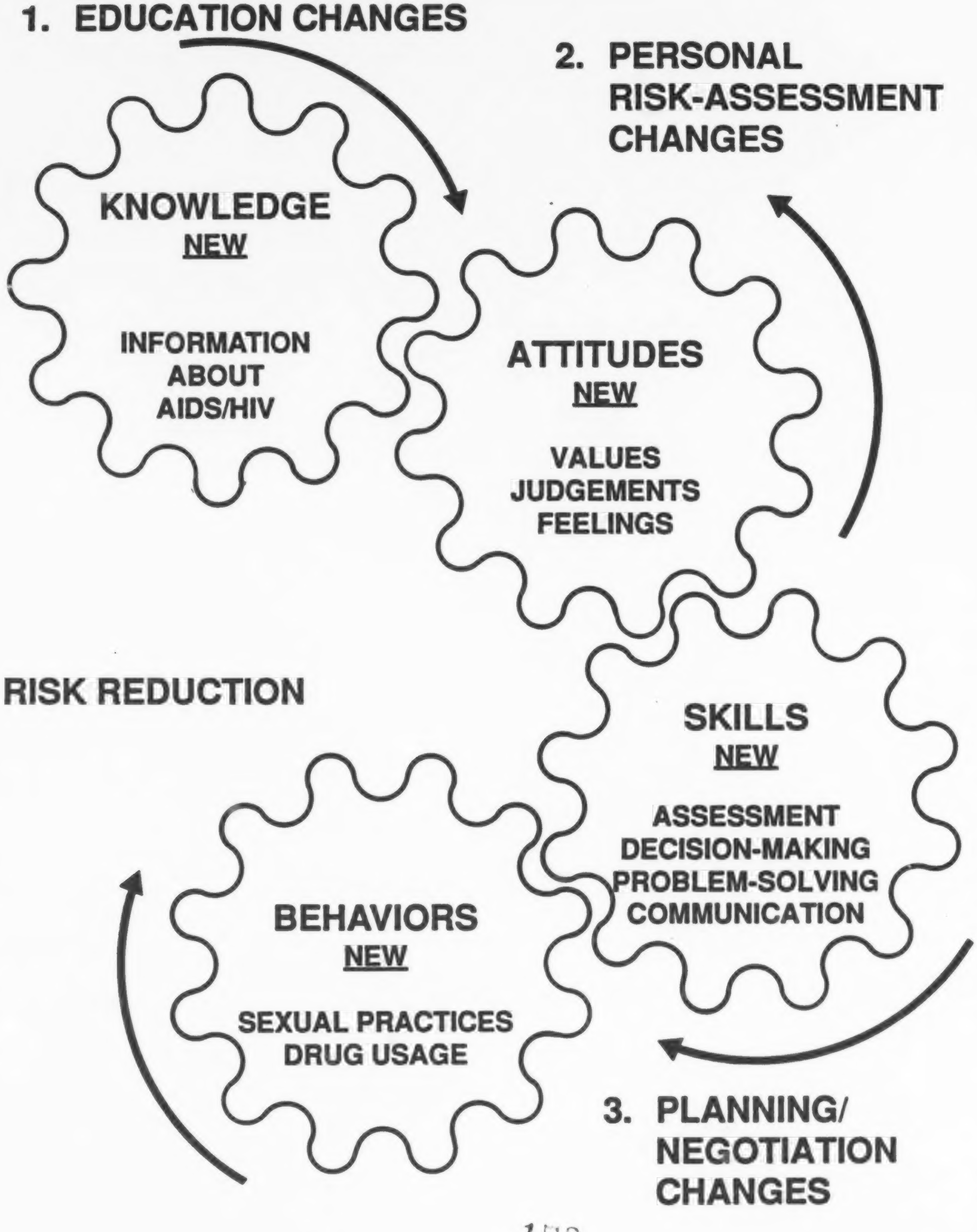
ASSESSMENT
DECISION-MAKING
PROBLEM-SOLVING
COMMUNICATION

BEHAVIORS
OLD

SEXUAL PRACTICES
DRUG USAGE

CONTINUED
AT-RISK
BEHAVIOR

PREVENTION INTERVENES WITH ALL FOUR ELEMENTS



1. EDUCATION CHANGES

2. PERSONAL RISK-ASSESSMENT CHANGES

KNOWLEDGE
NEW

INFORMATION
ABOUT
AIDS/HIV

ATTITUDES
NEW

VALUES
JUDGEMENTS
FEELINGS

RISK REDUCTION

SKILLS
NEW

ASSESSMENT
DECISION-MAKING
PROBLEM-SOLVING
COMMUNICATION

BEHAVIORS
NEW

SEXUAL PRACTICES
DRUG USAGE

3. PLANNING/ NEGOTIATION CHANGES

EDUCATION THAT RESULTS IN HEALTHY BEHAVIORS

By the early 1980s, health education had shifted from an earlier foundation that emphasized information and scare tactics toward an emphasis on affective education and personal skills development. Today, certain curriculum models can:

- Enhance health knowledge;
- Promote higher level cognitive skills;
- Influence the affective domain; and
- Influence practice.

Evaluation of these curricula, which focus on such topics as nutrition, cardiovascular health, drinking and driving, and use of seatbelts, has demonstrated success in improving knowledge, attitudes, skills, and targeted behaviors. Based on evaluations, it appears that the most important factor influencing student health knowledge, attitudes, and practices is time: 50 hours of health instruction yearly are needed to maximize curriculum effect.

In addition, such factors as extent of curriculum implementation, which is most affected by teacher inservice training, and educators' priorities carry significant influence on a program's success. As demonstrated by the School/Community Program for Sexual Risk Reduction Among Teens (South Carolina), programs that involve an intensive school- and community-based (agency professionals, parents, teachers, clergy) educational effort can result in reduced incidence of targeted behaviors.*

Evaluation also points out why education may not be successful in influencing behavior. Obstacles include: conflict regarding appropriate curriculum models (responsible decision-making vs. "Just Say No"); conflicting government policies (support of tobacco industry); lack of specialized school programs for high-risk students; lack of parental support; nonschool influences.

The National Institute of Mental Health is currently supporting research to test educational HIV prevention methods for adolescents. A project being conducted by the HIV Center for Clinical and Behavioral Studies at Columbia University, for example, is aimed at adolescents who are only potentially at risk of infection. The study is looking at the effects of education that conveys information vs. information plus personalized knowledge, social skills, decision-making, and planning. Other studies are examining educational programs directed at high-risk adolescents.

Much of this briefing paper is based on "School Health Education: A Foundation for School Health Programs," by David K. Lohrmann, Robert S. Gold, and Wanda H. Jubb, Journal of School Health, Vol. 57, No. 10, December 1987.

*This project is described in "Reducing Adolescent Pregnancy Through School- and Community-Based Education," by Murray L. Vincent, Andrew F. Clearie, and Mark D. Schluchter, Journal of the American Medical Association, Vol. 257, No. 24, June 26, 1987.

COMPREHENSIVE HEALTH EDUCATION

SEQUENTIAL, K-12

ADDRESSES DIMENSIONS OF HEALTH

PHYSICAL
MENTAL
EMOTIONAL
SOCIAL

PROVIDES OPPORTUNITIES TO DEVELOP AND DEMONSTRATE HEALTH-RELATED

KNOWLEDGE
ATTITUDES
SKILLS
PRACTICES

CONTENT AREAS

COMMUNITY HEALTH

CONSUMER HEALTH

ENVIRONMENTAL HEALTH

FAMILY LIFE AND HUMAN SEXUALITY

GROWTH AND DEVELOPMENT

NUTRITIONAL HEALTH

PERSONAL HEALTH

PREVENTION AND CONTROL OF DISEASE AND DISORDERS

SAFETY AND ACCIDENT PREVENTION

SUBSTANCE USE AND ABUSE

HIV EDUCATION CAN BE INTEGRATED INTO

BIOLOGY/SCIENCE

SOCIAL STUDIES

HEALTH

FAMILY LIFE EDUCATION

PSYCHOLOGY

CURRENT EVENTS

CIVICS/HISTORY

ETHICS

OTHER? ____________

RESOURCES

GUIDELINES

EDUCATION DEPARTMENT

STATE CURRICULUM GUIDELINES

CENTERS FOR DISEASE CONTROL (CDC)

MATERIALS

PUBLISHED CURRICULA

AUDIO-VISUAL AND OTHER SUPPLEMENTAL MATERIALS

AIDS SCHOOL HEALTH EDUCATION SUBFILE OF CHID (Combined Health Information Database)

INFORMATION

AIDS HOTLINES

MEDICAL JOURNALS/PUBLICATIONS

SURVEILLANCE REPORTS (CDC, state health departments)

LOCAL HEALTH DEPARTMENTS

ORGANIZATIONS (American Red Cross, hospitals, medical societies)

EDUCATIONAL RESEARCH

NATIONAL DIFFUSION NETWORK

EDUCATIONAL JOURNALS

EDUCATION ASSOCIATIONS

PERSONNEL

SCHOOL STAFF

PUBLIC HEALTH AGENCIES

NONPROFIT ORGANIZATIONS (American Red Cross, Planned Parenthood, medical societies/associations, AIDS service/education organizations)

COMMUNITY ADVISORY COMMITTEES

WHY DOES A SCHOOL BOARD NEED WRITTEN POLICIES?

A school board is an elected public body with authority to set direction for the school system. Just as laws that are established by the legislature must be in writing, so should school board policies be in writing. Increasingly, the legislature, the state board of education, and the courts are demanding written statements of policy.

1. Written school board policies foster stability and continuity. Board members come and go; staff people leave, retire, or are separated. But policy endures. A policy book, containing current policies and regulations, permits smooth transitions when changes take place.

2. Written policies available in an organized collection keep people informed about the board's goals and its position on major educational operational problems. When any public body operates in the open there can be no charges of secrecy. Accountability becomes reality.

3. Written policies and regulations clarify board-superintendent relations. When the board gives the school superintendnet the kind of broad directions he or she needs, the superintendent can administer the school system and get jobs done.

4. Written policies and regulations save time and effort for the superintendent. When problems come up--the use of school buildings by private groups, criticism against textbooks--the superintendent does not have to go to the board each time for a decision. He or she can take care of the matter on the basis of the board's standing statements.

5. Written policies save time and effort for the board. When policy and regulations exist, there need not be long board discussion on details of administration--that's the superintendent's job. There need not be a rerun of arguments on a problem which has been settled before. There need not be tedious arguments late into the night. "We enacted a policy and saw regulations on that question last year," is all that needs to be said to end the discussion and to move on to the next order of business.

DEVELOPING AN HIV EDUCATION POLICY

Should your board adopt a specific policy on HIV education?

Your existing policies should provide sufficient guidance and information regarding why and how instructional programs are developed and implemented. Nevertheless, the subject is worthy of discussion by your board for several reasons:

- A board policy can convey the board's commitment to HIV education and dispel family and teacher concerns that HIV instruction is occurring in an ad hoc manner determined by individual teachers or schools.
- A board policy can define the school system's role in providing HIV education and its relationship to education and services provided by other agencies and organizations.
- The means--the policy development process--may be as important as the end--the policy. Through a policy devElopment process that involves all segments of the school community, support for HIV instruction can be increased and consensus can be reached on the design of the program. Because of the sensitive nature of information about the transmission of HIV, consensus about who will be taught, what will be taught, and who will teach can minimize later controversy.
- A board policy can provide guidance to staff by including program objectives (e.g., emphasis on abstinence), and by requiring such activities as teacher inservice, coordination with other agencies, and program evaluation.
- Board policy on HIV education can assure the school community that processes exist for parental involvement (e.g., review of instructional materials) and expression of individual concerns (e.g., opt out procedures).

OVERCOMING BARRIERS TO HIV EDUCATION

For each of the potential barriers to HIV education listed, work with your tablemates to identify strategies for overcoming it.

1. Community attitudes and values.

2. Special-interest groups.

3. Objections to sex education.

4. Changing information about HIV.

5. Apathy toward AIDS epidemic.

6. Ill-equipped teachers.

7. Lack of curriculum.

8. Inertia toward, or avoidance of, topic by board (fear of controversy).

ADVISORY COMMITTEES

BENEFITS

INVOLVES CRITICS

HEAR DIVERSE VIEWPOINTS

CONSENSUS POSSIBLE

BUILDS SUPPORT

SOURCE OF NEW INFORMATION

DRAWBACKS

SLOWS PROCESS

POOR RECOMMENDATIONS POSSIBLE

BURDEN ON STAFF TO MANAGE

FORMING AN HIV EDUCATION ADVISORY COMMITTEE

Your school board has decided that the best approach to developing your HIV education program is to establish an advisory committee that will have the following charge:

To recommend to the board:

- Content, by grade level, of the HIV curriculum;
- Written and audio-visual materials to be used, by grade level;
- Who will teach the curriculum;
- A plan for selecting and training teachers;
- A plan for evaluating the curriculum and its delivery; and
- A plan for incorporating new information into the curriculum.

Based on your knowledge of your community and on your experience in working with advisory committees, what categories of people would you want represented on the committee?

____

____

____

____

____

____

____

____

____

____

____

____

____

____

ADVISORY COMMITTEES

WHO BELONGS?

PARENTS

STUDENTS

TEACHERS

PRINCIPALS

CURRICULUM SPECIALISTS

RESEARCH AND EVALUATION SPECIALISTS

SCHOOL NURSES

PUBLIC HEALTH OFFICIALS

MEDICAL EXPERTS

CLERGY

CIVIC ORGANIZATION REPRESENTATIVES

OTHERS?

PEOPLE WHO HAVE AIDS?

PROFESSIONAL HIV EDUCATORS?

?

HOW YOU COMMUNICATE
AFFECTS PEOPLE'S ATTITUDES AND RESPONSES

KEYS TO COMMUNICATION

1. UNDERSTAND WHAT IS BEING SAID
2. LISTEN CAREFULLY -- TO FEELINGS
3. HAVE KNOWLEDGE AND USE LOGIC.
4. EXPLAIN YOUR VIEWS.
5. EVALUATE YOUR RESPONSES BEFORE SPEAKING.

COMMUNICATION SKILLS: HOW WOULD YOU RESPOND?

Read each of the following statements and write down your best response in the space provided.

1. "I want guarantees that anybody who teaches students about HIV is heterosexually married. That's the only way we can be sure the right values are being taught."

   ____

   ____

   ____

2. "The only message schools should be giving students about HIV is to abstain from sex until they're married."

   ____

   ____

   ____

3. "Telling students that condoms can protect them from being infected by HIV if they have sex is irresponsible. I've seen articles that say condoms can't even be counted on to prevent pregnancy. How can you expect them to prevent HIV infection?

   ____

   ____

   ____

4. "If we teach kids about sexual intercourse, they'll think we condone their doing it."

   ____

   ____

   ____

(continued)

COMMUNICATION SKILLS: HOW WOULD YOU RESPOND? (continued)

5. "I hear you're going to teach first graders about HIV. That's too young to teach kids about sex and drugs."

6. "There's no way my I'm going to let my child be in that HIV education class. I'll sue the school board to keep him out if I have to."

7. "What makes you think teaching kids about HIV is going to protect them? Kids always think it's somebody else who should be careful."

8. "I'll tell my kids everything they need to know about HIV. It's my job, not the school's."

RESPONSES TO COMMON CONCERNS--Part I

Discussion of AIDS and HIV, particularly what, how, and when children will be taught about it, is a sensitive issue for most people. Some difficult questions may arise. Here are some common concerns and suggested responses taken from STATS, Students Teaching AIDS to Students, a Project of the American Medical Student Association (1988) that was developed for grades 7-12.

"Talking about sex will give my children ideas."

If a child is pressured into experimenting with sex or drugs, that pressure is most likely to come from his or her peers. It is the teacher's role to provide the child with information to help resist the pressures or to handle them in a responsible way.

Most children already have the ideas, as evidenced by the pregnancy rate and other statistics on sexual activity among adolescents.

Silence has not stopped sex or drug experimentation.

"What are you going to say about homosexuality?"

We are talking about risk behaviors, not risk groups. The focus is on sexual practices, and it doesn't matter if people are gay or straight.

By the time they reach junior high school, most children already have heard the words gay, queer, or fag and know what they mean.

"My kids are good. They don't need this class."

Most children are under a great deal of pressure to experiment.

Refer to statistics (More than half of teenagers polled reported sexual intercourse by age 17; only 33 percent of those who are sexually active said they "always use contraceptives;" 27 percent said they "never use contraceptives").

Is your local community devoid of drug use, teen pregnancy, or sexually transmitted disease problems?

"What are you going to say about condoms?"

Abstinence will be emphasized as the only sure way of avoiding transmission. However, statistics tell us that 80 percent [of people] have intercourse by age 20. The only known way to reduce the risk of transmission during intercourse is to use a condom properly. The bottom line is the health of your children, and condoms must be discussed to protect their health.

(continued)

RESPONSES TO COMMON CONCERNS--Part I (continued)

"We don't really know that there aren't other means of transmission besides sexual contact and needles. How can I be sure you are not endangering my children by telling them it is safe to have casual contact with people known to carry the virus?"

We *do* know a great deal about AIDS and HIV transmission. What is unknown is how to cure the disease once the virus has been passed.

The four percent of AIDS cases that fall into the "unknown method of transmission" category are mostly persons who failed to respond to follow-up questioning to determine their risk behaviors, persons who were diagnosed after death, or those who have been unwilling to discuss their risk activities.

Sex education will encourage my child to have sex."

A nationwide study by researchers at Johns Hopkins University concluded that "the data seem to provide *overwhelming support* for the claim that the decision to engage in sexual activity is *not influenced* by whether or not teenagers have had sex education in school. There is no association between sexual activity and courses that cover contraception."

No evidence supports the beliefs that sex education will increase or decrease the sexual activity of participants. (Douglas Kirby, *An Analysis of U.S. Sex Education Programs and Evaluation Methods,* CDC, 1979.) A study of 100 eighth graders found sex education increased students' knowledge, but did not reduce their guilt feelings about having sex. (Guy Parcel and Dave Lultman, "Evaluation of Sex Ed Course for Young Adults," *Family Relations,* January 1981.)

A study of 100 high school students showed that teenagers did not become more permissive in their attitudes toward sexual behavior as a result of sex education. They did become more confident in their ability to make "correct" decisions about their own sexual behavior. (Loren Hoch, "Attitude Change as a Result of Sex Education," *Journal of Research in Science Teaching*, 1971, p.363.)

Reprinted with permission from the American Medical Student Association, Reston, Virginia.

RESPONSES TO COMMON CONCERNS--Part II

Concerns

Sex education pits parents against their children.

It opposes parents' values.

It is an invasion of privacy.

Parents don't want it.

Parents have the sole right to be a child's sex educator.

Responses

*Sex education supplements, not supplants, parents.

*It increases parent-child communications (i.e., parents have a greater chance to communicate their values).

*Eighty percent of adults favor it, and parents of children under 18 are even more likely to favor it.

*Curricula encourage teachers and students to discuss moral issues with parents.

*We offer programs for parents.

*Only one percent of parents refuse permission for their child to participate in sex education programs.

*In communities where parents are most involved, courses are more, not less, comprehensive (parents want a wide-ranging curriculum).

*One study showed that parents want the most help with the subjects schools often avoid: contraception, abortion, masturbation, homosexuality, values, emotions and feelings.

(continued)

RESPONSES TO COMMON CONCERNS--Part II (continued)

Concerns

Sex education promotes sexual behavior as long as contraception is used.

It is value-free and immoral.

It is brainwashing through role-playing.

It teaches how to have sex.

It is the cause of sexual activity and teenage pregnancy.

Children in "latency" period (between ages five to puberty) are not interested in sex.

Responses

*Sex education teaches children to make difficult decisions and resist peer pressure.

*It is based on fundamental values, including the advantages of knowledge as compared to ignorance, the importance of self-esteem in resisting exploitation, and the principle of relating to others in ways that increase and support dignity, worth, and equality.

*Rather than brainwashing, role-plays, as rehearsals for how to behave under pressure, are a more responsible approach than letting young people learn through trial and error.

*Both psychiatric opinion and the number and range of questions children of all ages ask about sex show the "latency" period to be an invalid concept. If parents think it [sex education] will harm children, they can excuse them.

*Only ten percent of youth have a comprehensive sex education course, yet over fifty percent have had sexual intercourse--these sexual activity rates have increased during a time of minimal sexuality education.

*Research shows that education does not cause sexual activity, but that it does increase knowledge and tolerance for others whose values are different. If contraceptive information is included, programs can reduce unplanned pregnancy. Education also increases parent-child communication about sex.

Reprinted with permission from The Front Lines of Sexuality Education: A Guide to Building and Maintaining Community Support, Network Publications, a division of ETR Associates, 1984, Santa Cruz, Calif.

ACTION PLAN FOR HIV EDUCATION

Here is a list of important steps that should be taken as planning and decisions are made about HIV education in your schools. When you return home, you can use this checklist as a guide.

Planning

______ Collect community data on the incidence of AIDS.

______ Collect community data on the prevalence of teen risk behaviors and on their HIV-related knowledge and attitudes.

______ Find out about community HIV education efforts and resources.

______ Find out about state education department and state and local health department plans, requirements, and resources.

______ Identify support systems and barriers in the community.

______ Establish a process for staff, parent, student, and community involvement in planning, implementation, and evaluation.

______ Establish effective communications plan

Implementation

______ Get assistance and resources from health department (local or state).

______ Establish an advisory committee.

______ Adopt policies on employees and students who have AIDS or HIV infection.

______ Adopt policy on HIV-education: examine and revise existing policies to assure appropriate planning, implementation, and evaluation of HIV education; develop a plan and policies to implement HIV education within a more comprehensive K-12 program of school health education.

______ Support curriculum development plans with necessary resources.

______ Support identified inservice plans necessary for implementation.

______ Plan for evaluation of HIV education efforts.

Evaluation

______ Receive periodic status reports on implementation of HIV education and progress toward providing HIV education within the context of more comprehensive health education.

______ Receive periodic status reports on needs (HIV-related knowledge, attitudes, and behaviors among teens).

______ Identify continuing or new barriers and revise plans appropriately.

______ Determine success of education plan in meeting objectives.

______ Revise plans as necessary.

HIV EDUCATION RESOURCES

The following is neither a comprehensive list of AIDS/HIV resources, nor a list of resources endorsed by the National School Boards Association. Rather, the list provides access to information from a variety of resources that may prove helpful as local curriculum development and implementation occur.

Hotlines

State and local hotlines ______________________

National AIDS Hotline (Public Health Service) 800/342-AIDS
AIDS Information in Spanish 800/344-SIDA

Organizations

AIDS Action Council
729 8th St., SE
WAshington, DC 20003 202/547-3101

American Foundation for AIDS Research (AmFAR)
40 W. 57 St.
New York, NY 10019-4001 212/333-3118

American Red Cross
AIDS Education Program
National Headquarters
1730 D St., NW
Washington, DC 20006
Contact your local chapter or regional operations headquarters.

Center for Population Options
1012 14th St., NW, Suite 1200
Washington, DC 20005 202/347-5700

National AIDS Information Clearinghouse
P.O. Box 6003
Rockville, MD 20850 1-800/458-5231
(Contact this clearinghouse for copies of the Surgeon General's Report on AIDS, CDC Guidelines for Effective School Health Education to Prevent the Spread of AIDS and other CDC reports.)

National AIDS Network
1012 14th St., NW, Suite 601
Washington, DC 20005 202/347-0390

National Association of People with AIDS
2025 I St., NW, Suite 415
Washington, DC 20006 202/429-2856

National Association of State Boards of Education
1012 Cameron St.
Alexandria, VA 22314 703/684-4000

(continued)

HIV EDUCATION RESOURCES (continued)

National Coalition of Advocates for Students
100 Boylston St., Suite 737
Boston, MA 02116 617/357-8507

National Council of Churches
AIDS Task Force
475 Riverside Drive, Room 572
New York, NY 10115 212/749-1214

National Education Association
The Health Information Network
100 Colony Square, Suite 200
Atlanta, GA 30361 404/875-8819

National Minority AIDS Council
P.O. Box 28574
Washington, DC 20038 202/544-1076

The National PTA
700 N. Rush St.
Chicago, IL 60611 312/787-0977

National Rural and Small Schools Consortium
National Rural Development Institute
Miller Hall 359
Western Washington University
Bellingham, WA 98225 206/676-3576

Planned Parenthood Federation of America
810 7th Ave.
New York, NY 10019 212/541-7800

San Francisco AIDS Foundation
333 Valencia St., 4th Floor
San Francisco, CA 94103 415/864-4376

Sex Information and Education Council
of the U.S. (SIECUS)
32 Washington Pl., 5th Floor
New York, NY 10003 212/673-3850

Background and Information Sources

AIDS, Opposing Viewpoints Series, 1988, Greenhaven Press, 577 Shoreview Park Road, St. Paul, MN 55126.

AIDS and Adolescents: The Time for Prevention Is Now, Center for Population Options, 1012 14th St., NW, Washington, D.C. 20005; 202/347-5700.

AIDS and Adolescents/Resources for Educators, annotated bibliography, July 1987, Center for Population Options, 1012 14th St., NW, Washington, DC 20005; 202/347-5700.

(continued)

HIV EDUCATION RESOURCES (continued)

The AIDS Challenge: Prevention Education for Young People, ed. Marcia Quackenbush and Mary Nelson with Kay Clark, 1988. Network Publications, ETR Associates, P.O. Box 1830, Santa Cruz, CA 95061-1830; 408/438-4080.

AIDS Education: Curriculum and Health Policy, (Fastback 265), William L. Yarber, 1987, Phi Delta Kappa, 8th & Union, Box 789, Bloomington, IN 47402.

AIDS Education at Home and School: An Activity Guide for Local PTA Leaders. The National PTA, 700 North Rush St., Chicago, IL 60611-2571; 312/787-0977.

AIDS and the Education of Our Children: A Guide for Parents and Teachers, 1987, U.S. Department of Education, Office of Public Affairs, 400 Maryland Ave., NW, Washington, DC 20202.

AIDS Educator: A Catalog of AIDS Educational Material. San Francisco AIDS Foundation, 333 Valencia St., 4th Floor, San Francisco, CA 94103; 415/864-4376.

AIDS Information Resource Directory, 1988, American Foundation for AIDS Research, 40 West 57 St., New York, NY; 212/333-3118.

AIDS and Safer Sex Education: An Annotated Bibliography of Print and Audio-Visual Materials for Sale, SEICUS, Sex Information and Education Council of the U.S., New York University, 32 Washington Pl., New York, NY 10003; 212/673-3850.

AIDS School Health Education Subfile, Combined Health Information Database (CHID), Centers for Disease Control, BRS Information Technologies, 1200 Route 7, Latham, NY 12110; 800/345-4277 (access fees).

Confronting AIDS: Directions for Public Health, Health Care, and Research, 1986, and Confronting AIDS: Update 1988, Institute of Medicine, National Academy Press, 2101 Constitution Ave., NW, Washington, DC 20418.

Criteria for Evaluating an AIDS Curriculum, 1988, National Coalition of Advocates for Students (NCAS), 100 Boylston St., Boston, MA 02116; 617/357-8507.

Dealing With AIDS: Breaking the Chain of Infection, 1988, American Association of School Administrators, 1801 N. Moore St., Arlington, VA 22209; 703/528-0700.

Educating about AIDS, 1988 Supplemental Catalog, Network Publications, ETR Associates, P.O. Box 1830, Santa Cruz, CA 95061; 408/438-4080.

Effective AIDS Education: A Policymaker's Guide, 1988, National Association of State Boards of Education, 1012 Cameron St., Alexandria, VA 22314; 703/684-4000.

Guidelines for Effective School Health Education to Prevent the Spread of AIDS, 1988, Centers for Disease Control, National AIDS Information Clearinghouse, P.O. Box 6003, Rockville, MD 20850; 1-800/458-5231.

(continued)

HIV EDUCATION RESOURCES (continued)

Publications from Planned Parenthood (catalog), Planned Parenthood Federation of America, Inc., Education Department, 810 Seventh Ave., New York, NY 10019; 212/541-7800.

Reducing the Risk: A School Leader's Guide to AIDS Education, 1989, National School Boards Association, 1680 Duke St., Alexandria, VA 22314; 703/838-6722.

Report of The Presidential Commission on the Human Immunodeficiency Virus Epidemic, 1988, U.S. Government Printing Office, Washington, DC 20402.

Schools Face the Challenge of AIDS, 1989, Education Development Center, Inc., 55 Chapel St., Newton, MA 02160; 617/969-7100.

Surgeon General's Report on Acquired Immune Deficiency Syndrome (English and Spanish), 1986, National AIDS Information Clearinghouse, P.O. Box 6003, Rockville, MD 20850; 1-800-458-5231.

School Board Policy

AIDS and the Law: A Guide for the Public, 1987, Yale University Press, 92A Yale Station, New Haven, CT 06520.

AIDS and the Public Schools, 1986, National School Boards Association, 1680 Duke St., Alexandria, VA 22314; 703/838-6722.

NSBA/Educational Policies Service (EPS), Policy Information Clearinghouse, 1680 Duke St., Alexandria, VA 22314; 703/838-6722.

Policy services of state school boards associations--contact your state school boards association for information.

Communication Skills and Community Relations

Workshops and publications offered by many state school boards associations--contact your state school boards association for information.

Workshops and publications offered by the National School Public Relations Association (NSPRA), 1501 Lee Highway, Arlington, VA 22209; 703/528-5840.

HIV EDUCATION WORKSHOP EVALUATION

Please answer the following questions. Your candid and thorough responses will assist the association in planning future presentations.

I am ____ a board member ____ a superintendent ____ other __________ (specify)

1. Please rate each of the following components of this workshop by circling the appropriate number (write any comments in the appropriate spaces):

	Excellent	Good	Fair	Poor
Workshop Objectives				
Clarity	4	3	2	1
Relevance to your needs	4	3	2	1
Achievement in workshop	4	3	2	1

Comments ____

____

Subjects Covered

Medical Information				
Relevance to workshop	4	3	2	1
Clarity of presentation	4	3	2	1
Activities	4	3	2	1
Attitudes Toward HIV				
Relevance to workshop	4	3	2	1
Clarity of presentation	4	3	2	1
Activities	4	3	2	1
School Board Role				
Relevance to workshop	4	3	2	1
Clarity of presentation	4	3	2	1
Activities	4	3	2	1
HIV Instruction				
Relevance to workshop	4	3	2	1
Clarity of presentation	4	3	2	1
Activities	4	3	2	1
Policy Foundation				
Relevance to workshop	4	3	2	1
Clarity of presentation	4	3	2	1
Barriers to HIV Education				
Relevance to workshop	4	3	2	1
Clarity of presentation	4	3	2	1
Activities	4	3	2	1

	Excellent	Good	Fair	Poor
Communication Skills				
Relevance to workshop	4	3	2	1
Clarity of presentation	4	3	2	1
Activities	4	3	2	1

Comments____

____

Participant Notebook				
Usefulness to you in workshop	4	3	2	1
Anticipated future usefulness	4	3	2	1
Organization	4	3	2	1

Comments____

____

Audio-Visual Materials				
Usefulness to presentation	4	3	2	1
Organization	4	3	2	1
Clarity/visibility	4	3	2	1

Comments____

____

Presenters

__________________(School Governance)				
Knowledge of topic	4	3	2	1
Organization	4	3	2	1
Presentation skills	4	3	2	1
__________________(Health Educator)				
Knowledge of topic	4	3	2	1
Organization	4	3	2	1
Presentation skills	4	3	2	1
__________________(Medical Professional)				
Knowledge of topic	4	3	2	1
Organization	4	3	2	1
Presentation skills	4	3	2	1

Comments____

____

Overall workshop rating	4	3	2	1

Comments____

____

2. Did this workshop meet your expectations? ___Yes ___No
Why or why not?

3. Are there additional objectives this workshop should include?
(Please be specific.)

4. What I would like more of in this workshop is:

5. What I would like less of in this workshop is:

6. How will this workshop assist you in the future?

Additional comments and suggestions

CAMERA-READY TAKE-HOME MATERIALS

On the following pages you will find camera-ready copies of some of the activities that are included in the workshop curriculum provided in this manual. It is suggested that all or some of these pages be reproduced and provided to participants for use in their own communities. A camera-ready cover letter that conveys the intent of the materials package also is provided. You may want to distribute these materials at the end of the workshop or mail the package following the workshop.

Dear Workshop Participant:

We hope that your participation in this workshop has been a valuable experience and that what you have learned will contribute to your district's providing effective education to prevent the spread of HIV. As you plan your next steps, you may want to consider replicating some of your workshop experiences with your board colleagues, school district staff, or members of your community.

To assist you, enclosed are copies of some of the workshop exercises and instructions for conducting them. You may want to share these materials with your superintendent, health education specialist, and health department staff so they can be incorporated into inservice programs for the school board and for administrative, instructional, and support staff, and as programming for parents and community leaders. You also may use other materials from your workshop notebook to develop programs to meet your community's needs.

HIV PRETEST: WHAT DO YOU KNOW ABOUT HIV AND AIDS?

Precede a medical/epidemiologic presentation with this activity that gives people an opportunity to assess what they know about AIDS and HIV infection. The activity will open their minds to receiving information they may not know, or about which they may be uncertain or misinformed.

1. Ask participants to spend the next two to three minutes completing the pretest. This should be an individual exercise, not a group effort. Assure people that no one will collect their tests; they will not be graded. The pretest is to help them assess their basic knowledge about HIV.
2. Have participants save any questions they may have about HIV until after the medical presentation. Be sure to include time for questions following the medical presentation.
3. Following the medical presentation and question/answer period, tell participants that ALL the statements in the pretest are TRUE. Provide a few additional moments for clarification questions.

Helpful Hints:

- You may want to modify the statements about the number of reported cases of AIDS in the United States and in your state to reflect the number of reported cases in your community or region. Focusing on local conditions may have a greater impact on participants.
- To assure that the medical presentation is authoritative and understood by your audience, select a presenter who is professionally involved with HIV and who is adept at speaking about the complexities of HIV infection in language that lay people can understand. The presenter should recognize that explaining the nature of retrovirology is not as important as emphasizing and clarifying what is known about HIV transmission and how it can be prevented.
- To demonstrate to people the long-term severity of the HIV epidemic, you may want to develop a state or regional map showing the spread of AIDS over several years or a graph showing current and projected cases for the community, region, or state. Visual images frequently convey a stronger message than do words and numbers. Your state or local health department may already have developed such tools or may be able to assist you in developing them.

HIV PRETEST: WHAT DO YOU KNOW ABOUT HIV AND AIDS?

For each statement, circle the answer that you believe is most correct:
T = True F = False D = Don't know U = Undecided

1. The AIDS virus, HIV (human immunodeficiency virus), can cripple the body's immune system by destroying certain white blood cells. T F D U
2. There is no known cure or vaccine for HIV infection. T F D U
3. HIV can be transmitted by an infected person who has no symptoms of disease. T F D U
4. HIV is transmitted through vaginal, anal, or oral sexual contact, through direct blood-to-blood exchange such as through sharing of needles, or from an infected woman to child during pregnancy, childbirth, or breastfeeding. T F D U
5. Infection with HIV is usually diagnosed through blood tests for antibodies to the virus. T F D U
6. HIV does not survive long in the open air. T F D U
7. HIV is not transmitted through casual contact such as shaking hands, sneezing, coughing, insect bites, or eating foods prepared by an infected person. T F D U
8. By February 1989, more than 85,000 persons in the United States had been clinically diagnosed for AIDS, of which 57 percent had died. T F D U
9. The Centers for Disease Control estimates that 1 to 1.5 million people in the U.S. are infected with HIV. T F D U
10. Education about how to prevent infection with HIV by avoiding high-risk behaviors is a critically important means of stopping the AIDS epidemic. T F D U
11. Youth are at high risk of being infected with HIV if they are engaging in sexual intercourse or sharing needles to use drugs. T F D U
12. The most accessible sources of reliable information about HIV are local and state health departments and local, state, and national AIDS telephone hotlines. T F D U

Fill in the blank

________ cases of clinically diagonosed AIDS have been reported in this state.

DOES EDUCATION WORK TO PROMOTE GOOD HEALTH PRACTICES?

Lifestyles Fastball

This activity makes participants aware of the difference between providing information and actually giving health messages that influence behavior.

1. Ask participants to stand up. Tell them, "We are going to play 'lifestyles fastball.' I am going to make some statements. If a statement is not true for you, please sit down."

   - In the last month, I have always worn my seatbelt while driving.
   - I haven't smoked any cigarettes in the last year.
   - I eat a balanced breakfast every day.
   - I have not had alcohol before driving my car in the last month.
   - I exercise three times a week every week.
   - I get seven hours of sleep every night.
   - I floss my teeth every day.

   At the end of this exercise, most--if not all--participants will be seated and laughing.

2. Acknowledge what they have just realized: It takes more than information to affect people's behaviors. Explain that the challenge is even greater for young people because they believe they are immortal and invulnerable, they may base decisions on misinformation, they have a propensity for risk taking, and they are subject to peer pressure. When it comes to HIV infection, they say:

   -- "It won't happen to me."
   -- "We're in love and will be together forever." Definition of "forever" is three months.
   -- "Girls who carry condoms are sluts." "Boys who carry condoms are suckers."
   -- "I trust my friends."

   It requires a jump of faith to believe that merely dispersing information about HIV will lead to reduced risk for adolescents. Showing a film or spending one class session providing information is unlikely to influence behavior. Education that results in healthy behaviors needs to empower people to make good decisions based on correct knowledge and supported by usable skills.

TRANSITIONAL STATE

This "loss" exercise will help participants empathize with feelings associated with AIDS and lessen the distance they may be putting between themselves and the actuality of HIV infection. Personalizing HIV infection in this way should increase the value people place on the importance of HIV education.

This exercise would be particularly useful as part of teacher inservice, because a teacher's personal attitudes will affect the instruction provided. In addition, this exercise also would be effective in employee and community education programs and in a workshop dealing with policy issues related to people who have AIDS.

(Another effective way to personalize HIV infection is to have a person who is living with AIDS speak and respond to questions about the emotional, psychological, physical, and economic effects AIDS has on people. Your local health department or a community-based service organization may be able to help you find a person in your community who would be willing to come before your audience. Also, the National Association of People with AIDS (NAPWA) may be able to assist: 2025 I St., NW, Suite 415, Washington, DC 20006, 202/429-2856.)

You will need an overhead projector and blank transparency, a flipchart, or a chalkboard. Allow approximately 25 minutes for this exercise.

1. Hand out the worksheets and ask participants to follow the directions for listing:

   a. A material possession that you value dearly.
   b. A personal or physical attribute of which you are proud.
   c. A favorite physical activity.
   d. A personal secret that you share with few people or with no one. (Have them draw a circle around the secret to signal it is "hidden.")
   e. A friend or loved one whose support has been critical to you.

   Explain that this is an individual exercise and that no one will look at their answers.

2. Ask participants to consider each of the following developments. With the exception of item 4, ask them to "x-out" the item as you move through each.

   a. An unforeseen financial reversal causes you to lose or sell the material possession.
   b. An accident causes the physical attribute to be lostor severely marred.
   c. An accident renders it impossible for you to engage in your favorite activity.
   d. Through a combination of circumstances, your secret is "out." (Have them erase the circle "hiding" the secret.)
   e. Because a friend or loved one has discovered your secret, your important support person abandons you.

(continued)

3. Ask participants how they feel about these losses. List their responses on the blank transparency or flipchart. Be sure all the following are covered as reactions of persons in transition:

   -- self-devaluation
   -- anger or rage
   -- fear
   -- depression
   -- loss of control
   -- withdrawal or escapism.

4. Ask participants if they recognize the connection between their feelings and the reactions of HIV-infected people.

Helpful Hint: Before moving on, restore each of the lost items to participants. Whether through an "accident of fate" or "case of mistaken identity," they have regained everything. Allow a moment for relief taking. Emphasize that HIV-infected people cannot have their health "restored."

TRANSITIONAL STATE: EXPERIENCING LOSS

In the space below, list:

1. A material possession you value dearly.

2. A personal or physical attribute of which you are proud.

3. Your favorite physical activity.

4. A personal secret that you share with few people or with no one. (Draw a circle around the secret to signal that it is "hidden.")

5. A friend or loved one whose support has been critical to you.

WHO HAS AIDS?

Designed to make people aware that everyone is at risk of HIV infection if they preactice risky behaviors, this activity gives participants an opportunity to realize that personal decisionmaking is linked to HIV prevention.

Allow approximately 10 minutes for this exercise.

In advance, on envelopes equal to the number of participants, write under each envelope flap the letter A, B, or C; about 10 percent should be marked with an "A"; the remainder should be divided among "B" and "C" markings.

1. Distribute one envelope to each participant.

2. Ask participants to look under the flap of their envelope and remember the letter they see marked; they should not reveal the letter to anyone.

3. Ask participants to stand up, walk over to someone, and exchange envelopes. Have them write their first letter next to the letter marked inside the second envelope.

4. Have participants exchange envelopes again and write their first two letters next to the two marked inside the third envelope.

5. Tell participants: "Those of you who have seen an "A" have been exposed to the AIDS virus. Those of you who have seen only "B's" and "C's" are still safe. Now, how many of you want to exchange envelopes one more time?" There likely will be some nervous giggling and discomfort.

6. By asking the following questions, elicit participants' feelings about continuing the envelope exchange.

   -- "What is preventing you from wanting to exchange envelopes again?"

   -- "Is there some way in which you could exchange envelopes again but reduce your risk?" (Some people may suggest sealing the envelope, comparable to using a condom or cleaning a needle.)

7. Emphasize that you don't have to be infected with HIV by chance; you can reduce your risk if you know how.

OVERCOMING BARRIERS TO HIV EDUCATION

This activity gets participants to identify barriers to implementing HIV education in their communities and to think through ways to overcome them. Participants should complete this activity with the feeling that barriers are not insurmountable, but can be managed if they are anticipated.

Allow approximately 20 minutes for this exercise.

1. Ask participants what they foresee as barriers to implementing HIV education in their schools. You may want to use an overhead projector and write their responses on a blank transparency (or on a flipchart or chalkboard). Be sure to cover the following barriers:

   --Community values and attitudes
   --Special interest groups
   --Objections to sex education
   --Changing information about HIV
   --Apathy toward the HIV epidemic
   --Ill-equipped teachers
   --Lack of curriculum
   --Inertia of, or avoidance by, the board or school district due to fear of controversy.

2. Hand out the worksheets. Form groups of about five people each. Assign one to three barriers listed on the worksheet to each group and ask participants to identify appropriate means for overcoming each barrier assigned. Advise them to think about how policies set the stage for overcoming barriers, (e.g., policies that enable people to voice their opinions).

3. Group by group, ask volunteers to share their team's solutions with everyone. Guide the discussion to elicit the following says to overcome the respective barriers:

   Community values or attitudes: Provide opportunities for involvement through broad-based community advisory committees, education programs for parents/community, public hearings on curriculum adoption; allow parents to review instructional materials.

   Special-interest groups: Build support among majority of community; identify areas of agreement; involve special interest groups in planning; provide opportunities for all to be listened to; be willing to acknowledge that a different approach may be better--sometimes the most vocal people are right.

   Objections to sex education: Find out what is objected to; provide procedures for parents to have their children excused from some classroom instruction; educate community regarding how sex education is part of comprehensive health education; build on support of majority of community.

(continued)

OVERCOMING BARRIERS TO HIV EDUCATION (continued)

Changing information about HIV: Build in a process for periodic review of curriculum to incorporate new information based on authoritative medical evidence; determine criteria for evaluating information; show that scientific conclusions about how HIV is transmitted have remained stable.

Apathy toward HIV epidemic: Work with health authorities to provide relevant community education by assembling local and state data on AIDS and for STD, pregnancy, abortion, and illicit drug use among teens; enlist media support.

Ill-equipped teachers: Develop plan for staff selection and development/inservice; address teacher attitudes and values during inservice; involve staff in curriculum development; provide HIV education for all school employees; identify alternative community resources.

Lack of curriculum: Identify existing resources; consult with other districts; develop local curriculum.

Inertia toward, or avoidance of, topic by board or school district: Educate board members about HIV and the importance of HIV education; adopt policies that enable managing controversy; prepare board members to deal with controversy.

OVERCOMING BARRIERS TO HIV EDUCATION

For each of the potential barriers to HIV education listed, identify strategies for overcoming it.

1. Community attitudes and values.

2. Special-interest groups.

3. Objections to sex education.

4. Changing information about HIV.

5. Apathy toward HIV epidemic.

6. Ill-equipped teachers.

7. Lack of curriculum.

8. Inertia toward, or avoidance of, topic by board (fear of controversy).

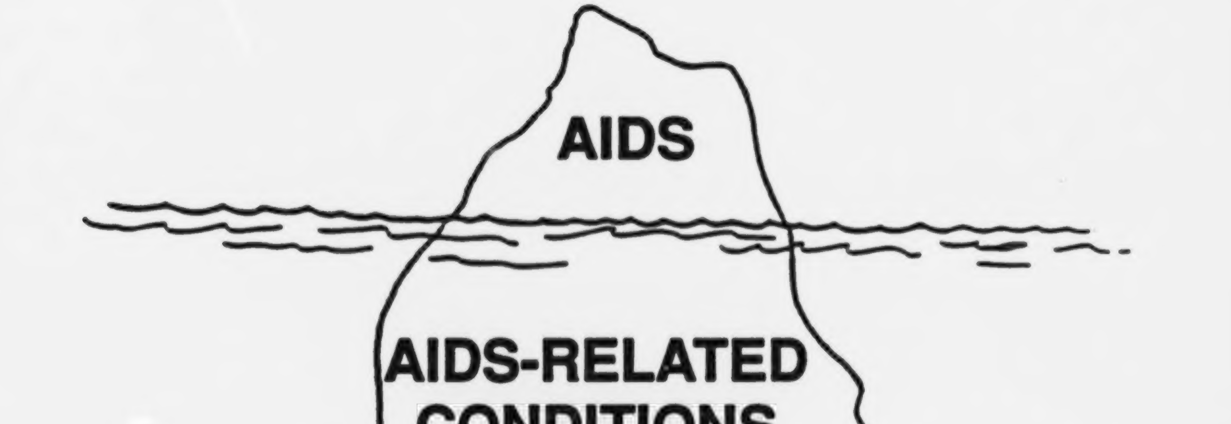
GOAL:

INFORMATION AND SKILLS
TO PROVIDE SCHOOL BOARD LEADERSHIP
FOR HIV EDUCATION

OBJECTIVES:

- CONVEY IMPORTANCE OF EDUCATION TO PREVENT SPREAD OF HIV
- CLARIFY SCHOOL ROLE/RESPONSIBILITY
- PROVIDE PROCESS FOR DEVELOPMENT/ IMPLEMENTATION
- ENHANCE SKILLS TO MANAGE CONTROVERSY
- PROVIDE ACCESS TO RESOURCES

CLINICAL SPECTRUM OF HIV INFECTION "ICEBERG MODEL"



AIDS

AIDS-RELATED CONDITIONS

ASYMPTOMATIC HIV INFECTION

TRI-LEVEL APPROACH TO EDUCATION TO PREVENT INFECTION WITH HIV

EDUCATION THAT ENABLES AND ENCOURAGES STUDENTS TO:

1. ABSTAIN FROM SEX
2. ABSTAIN FROM DRUGS

EDUCATION THAT ENABLES AND ENCOURAGES STUDENTS TO:

1. STOP HAVING SEXUAL INTERCOURSE UNTIL THEY ARE READY TO ESTABLISH A MUTUALLY MONOGAMOUS RELATIONSHIP
2. STOP USING OR INJECTING ILLICIT DRUGS

EDUCATION THAT ENABLES AND ENCOURAGES STUDENTS WHO ENGAGE IN RISKY BEHAVIOR TO:

1. AVOID SEXUAL INTERCOURSE WITH ANYONE INFECTED, AT RISK OF BEING INFECTED, OR WHOSE INFECTION STATUS IS UNKNOWN
2. USE LATEX CONDOM WITH SPERMICIDE WHEN ENGAGING IN SEXUAL INTERCOURSE
3. SEEK TREATMENT FOR DRUG ADDICTION
4. NOT SHARE NEEDLES OR OTHER INJECTION EQUIPMENT
5. SEEK COUNSELING/TESTING IF HIV INFECTION IS SUSPECTED

AIDS 3

INDICATORS OF YOUTH AT RISK OF HIV INFECTION

* SEXUAL ACTIVITY

- TEEN PREGNANCIES
- SEXUALLY TRANSMITTED DISEASES (STDS) AMONG TEENS
- CONTRACEPTIVE USE BY TEENS

* ILLICIT DRUG USE

- SCHOOL DISCIPLINARY ACTIONS
- ENROLLMENT IN TREATMENT PROGRAMS
- ARRESTS
- DEATHS RESULTING FROM DRUG USE

* SOURCES OF INFORMATION

- PUBLIC HEALTH AGENCIES
- SOCIAL SERVICE AGENCIES
- HOSPITALS AND MEDICAL ASSOCIATIONS
- NONPROFIT ORGANIZATIONS
  (E.G., AMERICAN RED CROSS, PLANNED PARENTHOOD)
- SCHOOL DISCIPLINARY RECORDS
- ARREST RECORDS
- CLERGY

SPHERES OF INFLUENCE ON STUDENTS

PROGRAM COMPONENTS THAT SUPPORT AIDS INSTRUCTION

Healthful School Environment

Administrators and Coordination

Instructional Program

Student Involvement Programs

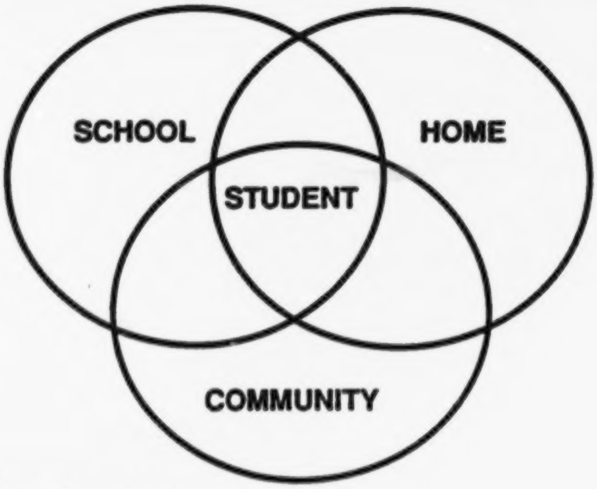
Supportive School Health Services

Supportive Home Environments

School-Community Sponsored Programs for Families

Educational Support

Parent Involvement in School Programs



Community Programs

Educational Support

Coordination Among Agencies

CRITERIA FOR AN HIV CURRICULUM

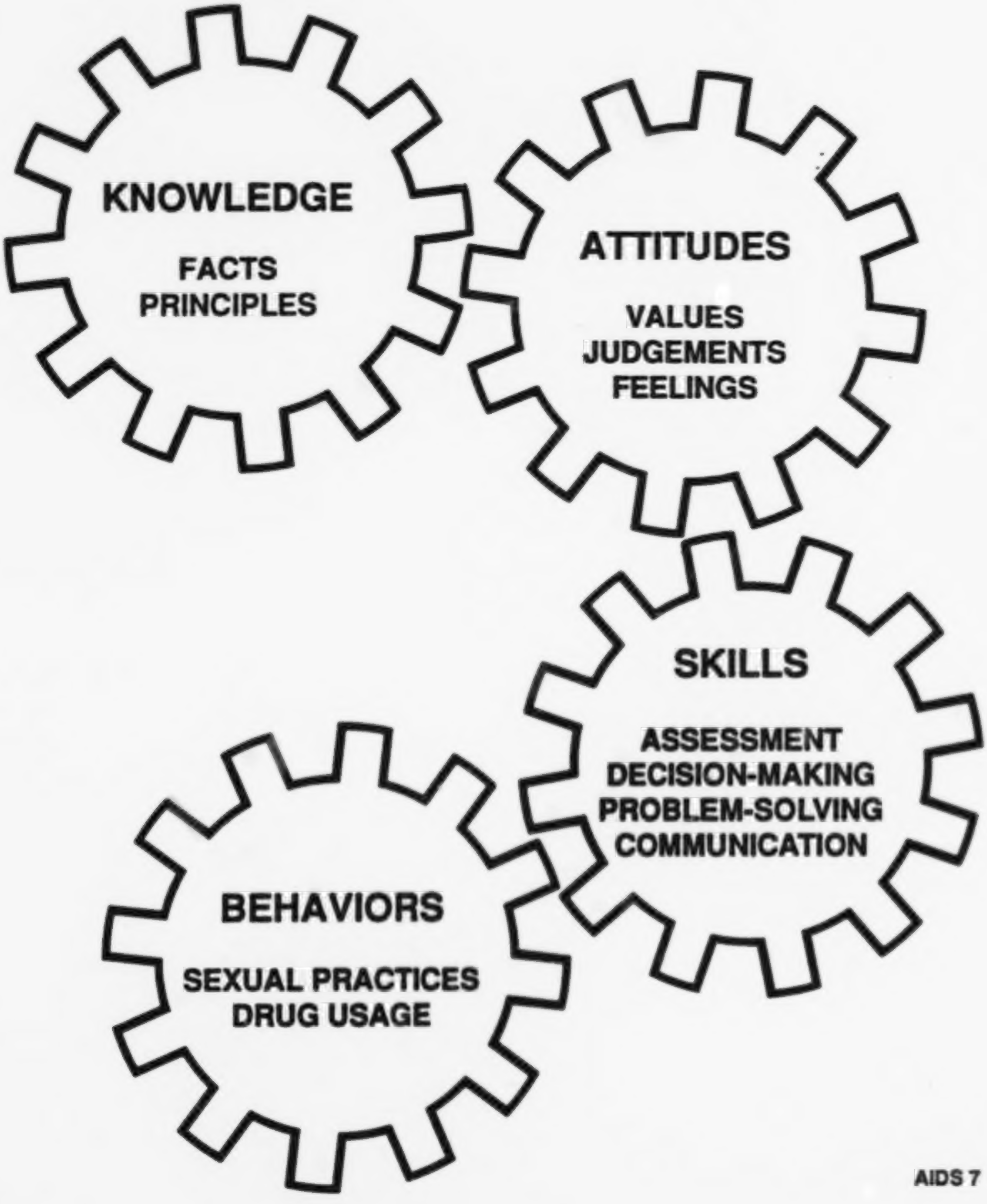
CONTENT

- INFORMATION IN CLEAR TERMS
- TEACH HEALTHY BEHAVIORS
- ANYONE CAN GET HIV INFECTION
- MULTIPLE LEARNING OPPORTUNITIES

DEVELOPMENT/IMPLEMENTATION

- TEACHER INVOLVEMENT
- TEACHER TRAINING
- SPECIAL NEEDS STUDENTS
- REGULARLY UPDATED
- PARTICIPATION OF PARENTS/COMMUNITY
- ONGOING DIALOGUE/EVALUATION

FOUR INDIVIDUAL ELEMENTS INTERACT TO SUPPORT ALL BEHAVIOR



KNOWLEDGE

FACTS
PRINCIPLES

ATTITUDES

VALUES
JUDGEMENTS
FEELINGS

SKILLS

ASSESSMENT
DECISION-MAKING
PROBLEM-SOLVING
COMMUNICATION

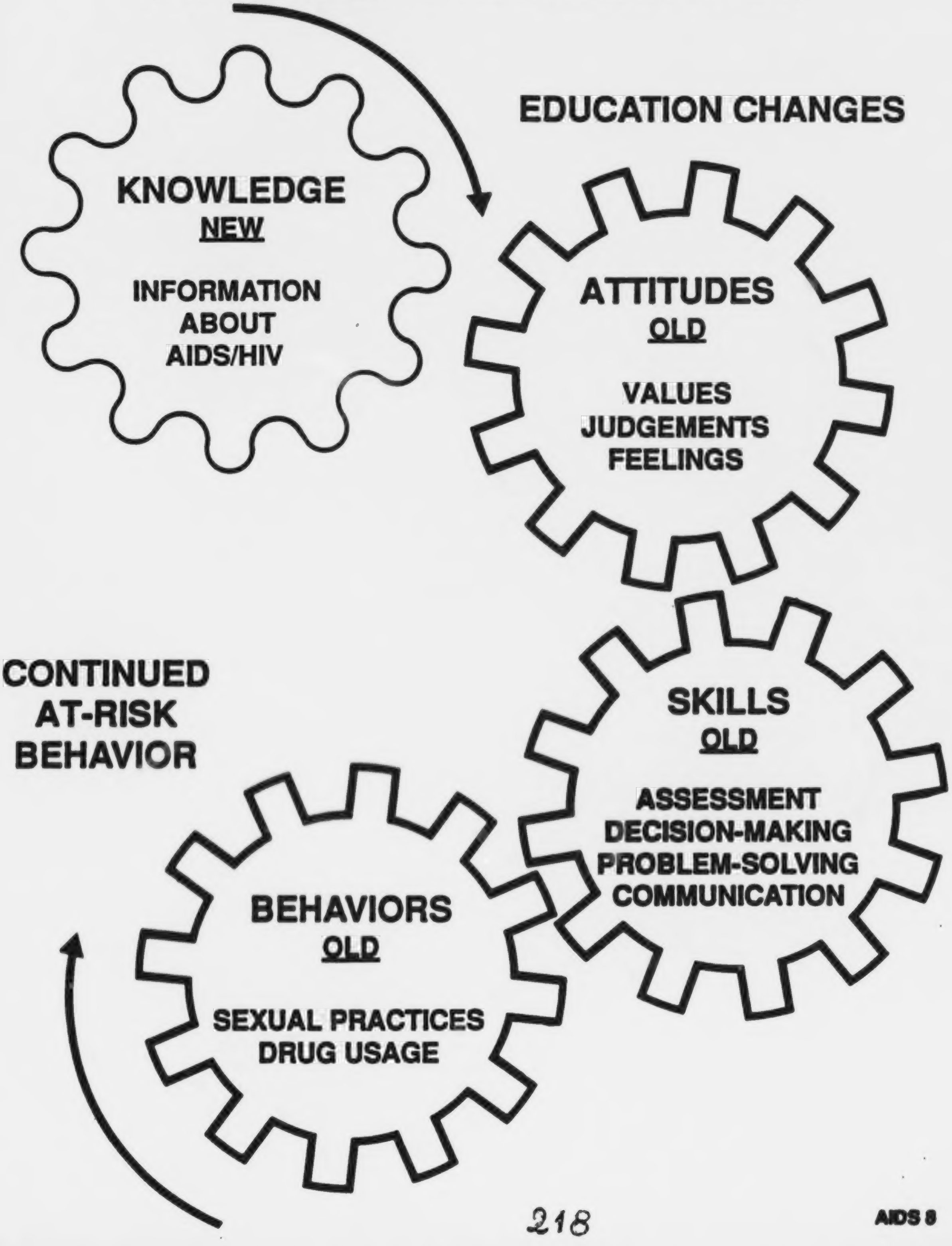
BEHAVIORS

SEXUAL PRACTICES
DRUG USAGE

AIDS 7

PREVENTION IS MORE THAN CONVEYING INFORMATION

(OR HOW NOT TO TEACH ABOUT AIDS)



EDUCATION CHANGES

KNOWLEDGE

NEW

INFORMATION
ABOUT
AIDS/HIV

ATTITUDES

OLD

VALUES
JUDGEMENTS
FEELINGS

**CONTINUED
AT-RISK
BEHAVIOR**

SKILLS

OLD

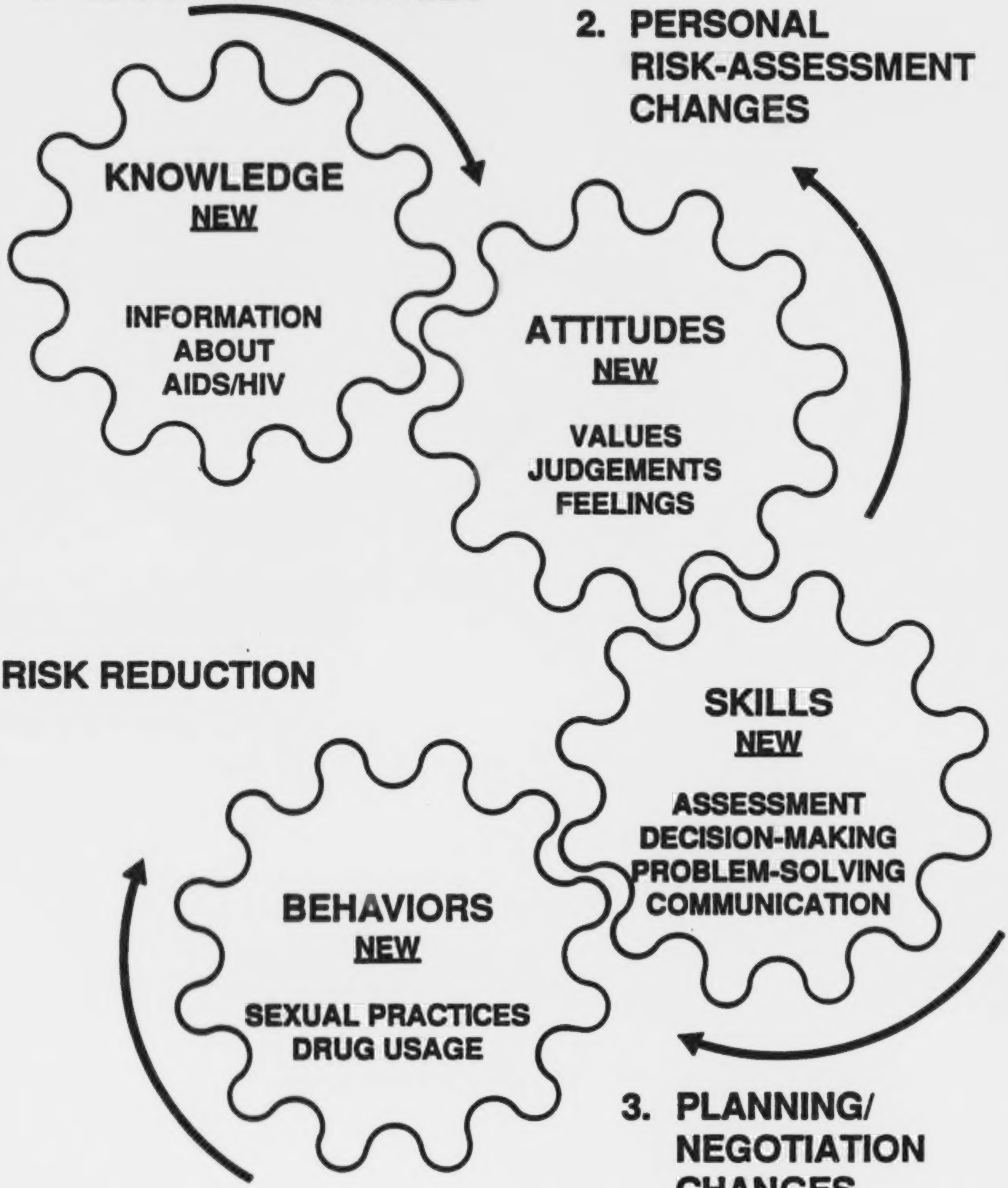
ASSESSMENT
DECISION-MAKING
PROBLEM-SOLVING
COMMUNICATION

BEHAVIORS

OLD

SEXUAL PRACTICES
DRUG USAGE

PREVENTION INTERVENES WITH ALL FOUR ELEMENTS



1. EDUCATION CHANGES

2. PERSONAL RISK-ASSESSMENT CHANGES

3. PLANNING/ NEGOTIATION CHANGES

RISK REDUCTION

KNOWLEDGE
NEW

INFORMATION
ABOUT
AIDS/HIV

ATTITUDES
NEW

VALUES
JUDGEMENTS
FEELINGS

SKILLS
NEW

ASSESSMENT
DECISION-MAKING
PROBLEM-SOLVING
COMMUNICATION

BEHAVIORS
NEW

SEXUAL PRACTICES
DRUG USAGE

COMPREHENSIVE HEALTH EDUCATION

SEQUENTIAL, K-12

ADDRESSES DIMENSIONS OF HEALTH:

- PHYSICAL
- MENTAL
- EMOTIONAL
- SOCIAL

PROVIDES OPPORTUNITIES TO DEVELOP AND DEMONSTRATE HEALTH-RELATED

- KNOWLEDGE
- ATTITUDES
- SKILLS
- PRACTICES

CONTENT AREAS

- COMMUNITY HEALTH
- CONSUMER HEALTH
- ENVIRONMENTAL HEALTH
- FAMILY LIFE AND HUMAN SEXUALITY
- GROWTH AND DEVELOPMENT
- NUTRITIONAL HEALTH
- PERSONAL HEALTH
- PREVENTION/CONTROL OF DISEASE AND DISORDERS
- SAFETY/ACCIDENT PREVENTION
- SUBSTANCE USE/ABUSE

HIV EDUCATION CAN BE INTEGRATED INTO

Biology/Science

Social Studies

Health

Family Life Education

Psychology

Current Events

Civics/History

Ethics

Other?

RESOURCES

GUIDELINES

- EDUCATION DEPARTMENT
- STATE CURRICULUM GUIDELINES
- CENTERS FOR DISEASE CONTROL (CDC)

MATERIALS

- PUBLISHED CURRICULA
- A/V AND OTHER SUPPLEMENTAL MATERIALS
- AIDS SCHOOL HEALTH EDUCATION SUBFILE (CHID)

INFORMATION

- AIDS HOTLINES
- MEDICAL JOURNALS/PUBLICATIONS
- SURVEILLANCE REPORTS
  (CENTERS FOR DISEASE CONTROL/STATE HEALTH DEPARTMENTS)
- LOCAL HEALTH DEPARTMENTS
- ORGANIZATIONS — RED CROSS, MEDICAL SOCIETIES

EDUCATIONAL RESEARCH

- NATIONAL DIFFUSION NETWORK
- JOURNALS
- ASSOCIATIONS

PERSONNEL

- SCHOOL STAFF
- PUBLIC HEALTH AGENCIES
- NON-PROFIT ORGANIZATONS — RED CROSS, MEDICAL SOCIETIES/ASSOCIATIONS, AIDS SERVICE/EDUCATION ORGANZATIONS
- COMMUNITY ADVISORY COMMITTEES

ADVISORY COMMITTEES

BENEFITS

- INVOLVES CRITICS
- DIVERSE VIEWPOINTS
- CONSENSUS POSSIBLE
- BUILDS SUPPORT
- SOURCE OF NEW INFORMATION

DRAWBACKS

- SLOWS PROCESS
- POOR RECOMMENDATION POSSIBLE
- BURDEN ON STAFF

ADVISORY COMMITTEES— WHO BELONGS?

PARENTS

STUDENTS

TEACHERS

PRINCIPALS

CURRICULUM SPECIALISTS

RESEARCH/EVALUATION SPECIALISTS

PUBLIC HEALTH OFFICIALS

SCHOOL NURSES

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OTHERS?

PEOPLE WHO HAVE AIDS?

PROFESSIONAL AIDS EDUCATORS?

HOW YOU COMMUNICATE AFFECTS PEOPLE'S ATTITUDES AND RESPONSES

KEYS TO COMMUNICATION

- UNDERSTAND WHAT'S BEING SAID
- LISTEN CAREFULLY — TO FEELINGS
- HAVE KNOWLEDGE/USE LOGIC
- EXPLAIN YOUR VIEWS
- EVALUATE RESPONSES BEFORE SPEAKING

AIDS and Children

Information for Teachers and School Officials

1798

American
Red Cross

U.S. Public
Health Service

AIDS (acquired immune deficiency syndrome) is a disease that breaks down the body's immune system, or its ability to fight disease. This leaves a person with AIDS vulnerable to life-threatening illnesses that do not affect people with normal immunity.

AIDS is caused by a virus* that infects and damages cells of the immune system. This virus can also infect cells of the central nervous system, causing mental and emotional disorders.

How Widespread Is AIDS Among Children?

The number of children with AIDS is small. Of the first 20,000 AIDS cases in the United States, fewer than 300 were children under 13 years old.

How Is AIDS Spread?

AIDS is a bloodborne disease, most often spread through sexual contact or sharing infected intravenous drug needles, or transmitted from infected mother to unborn or newborn infant. Specifically, AIDS is spread through—

- Sexual contact in which blood or body fluids (semen, urine, feces, vaginal secretions) are transmitted from an infected person to an uninfected person.
- Sharing drug needles contaminated with the AIDS virus. People who inject illicit drugs and share needles risk infection.
- Perinatal transmission. An infected woman can pass the virus to her child before, during, or shortly after birth.
- Transfusion of blood or blood components contaminated with the AIDS virus. The risk of infection through transfusion has always been slight, and is now extremely small. Use of a test to screen blood

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**The virus that causes AIDS and related disorders has several different names: HTLV-III, LAV, ARV, and most recently, HIV. In this brochure it is called "the AIDS virus."*

for exposure to the AIDS virus, together with voluntary deferral of donations by people at risk for AIDS, has made the blood supply very safe.

Can AIDS Be Spread Through Casual Contact?

No. The AIDS virus is very weak and does not survive well outside the body. It is easily killed by many common disinfectants, including household bleach. AIDS is not spread through everyday activities such as working in an office, attending school, eating in restaurants, swimming in public pools, shaking hands, hugging, or other casual contact. The virus is not spread through the air from sneezing or coughing. In five years of studying AIDS, scientists have not found one case caused by casual contact.

Who Is at Risk?

Anyone who engages in high-risk practices such as sharing needles to inject illicit drugs or having sex with an infected person can be at risk for AIDS. Of all the cases reported in the United States since 1981, 98 percent have been among the following groups of people:

- Sexually active homosexual and bisexual men (or men who have had sex with another man since 1977) (65 percent)
- Present or past abusers of illicit intravenous (IV) drugs (17 percent)
- Homosexual and bisexual men who are also IV drug abusers (8 percent)
- Persons who have had transfusions of blood or blood products (2 percent)
- Persons with hemophilia or other blood clotting disorders who have received blood clotting factors (1 percent)
- Heterosexual men and women (these include sex partners of persons with AIDS or at risk for AIDS, and people born in countries where heterosexual transmission is thought to be more common than in the United States) (4 percent)

- Infants born to mothers infected with the AIDS virus (1 percent)

About 2 percent of AIDS patients do not fall into any of these groups, but scientists believe that transmission occurred in similar ways. Some patients could not be followed up, or died before complete histories could be taken.

Do All People Infected With the Virus Develop AIDS?

Scientists cannot yet answer this question because AIDS is a new disease. Many people infected with the AIDS virus remain healthy and free of symptoms for months or years. Others develop AIDS-related complex (ARC), which may include symptoms of fatigue, weight loss, diarrhea, fever, chills, night sweats, and swollen glands. These symptoms last longer than they would in other illnesses, such as the flu. Some people with ARC may never develop AIDS.

People who develop AIDS may at first have the same symptoms as those with ARC, but they go on to develop rare, often fatal illnesses. The two most common are *Pneumocystis carinii* pneumonia, a parasitic infection of the lungs, and Kaposi's sarcoma, a type of skin cancer that appears as purplish patches on the skin or inside the mouth, nose, or eyelids.

It is important to know that *all* people infected with the AIDS virus—even those who remain completely free of symptoms—will probably be infectious their entire lives and able to pass the virus on to others.

How Do Children Get AIDS?

Most children with AIDS acquire the virus from their infected mothers before or during birth, either through the mother's blood system or in the birth canal. Most of the mothers were intravenous drug abusers or the sexual partners of men in a high-risk group. One child became infected shortly after birth, possibly from the mother's breast milk.

In rare cases, children have been infected through transfusion of blood or blood products. Now that all blood is screened for the AIDS virus, transfusion and hemophilia treatment pose only a very small risk.

About 5 percent of pediatric cases are still being investigated, but scientists strongly suspect that these children also became infected either before or during birth, or through blood transfusion.

Can Pediatric AIDS Be Prevented?

Yes. The risk of infection through blood transfusion and hemophilia treatment is now extremely small. So future cases of pediatric AIDS will likely be in infants born to infected mothers. These cases can be prevented if women at risk of infection are educated about the possible risk to their unborn or newborn babies. Women who are infected with the AIDS virus or are at increased risk of infection should avoid becoming pregnant until more is known about transmission to their babies. They should seek counseling and testing for infection with the AIDS virus from their physician or at a clinic. State and local health departments can tell women where they can go for testing. At increased risk of infection are—

- Women who inject illicit drugs.
- Women from Haiti and Central African countries.
- Prostitutes.
- Women who have had sex with—
  - IV drug users.
  - Bisexual men.
  - Men with hemophilia.
  - Men from Haiti and Central Africa.

What About the Schools?

Not one case of AIDS is known to have been transmitted in a school, day care, or foster care setting. AIDS is not spread through the kind of contact children have with each other, such as touching, hugging, or sharing meals and bathrooms. This is supported by long-term studies of family members of both adults and children with AIDS. Not one household member has become infected through routine, non-sexual contact with a family member with AIDS.

Is Going to School Risky for the Child With AIDS?

Children who have damaged immune systems, either from AIDS or other illnesses, risk suffering severe complications from infections commonly picked up in school or day care centers, such as chicken pox, tuberculosis, herpes, measles, and other diseases.

The child's doctor should evaluate the risk of infection, based on the child's immune status. The risk of acquiring some infections, such as chicken pox, may be reduced by prompt administration of specific immune globulin following exposure.

Public Health Service Guidelines for Local Authorities

The Public Health Service has developed recommendations to help state and local health and education departments formulate their own guidelines for the education and foster care of children with AIDS. These recommendations are designed to protect and promote the well-being of all children in school and day care settings.

- Decisions about education and care for children infected with the AIDS virus should be made by a team including the child's physician, public health personnel, parents or guardian, and school or day/foster care workers.
- Most infected school-age children should be allowed to attend school and after-school day care and, if needed, to be placed in a foster home. The benefits of an unrestricted setting outweigh the risks of their acquiring harmful infections. The risk of transmitting the virus to others is almost nonexistent.
- A more restricted environment is advised for infected preschool-age children, for children who

cannot control their bowels or bladder, for children who display such behavior as biting, and for infected children who have uncoverable, oozing sores. These children should be cared for and educated in settings that minimize the exposure of other children to their blood and body fluids.

- Persons who are exposed to an infected child's body fluids and excrement (when changing diapers, for example) must know that the child is infected and must know procedures to follow to prevent transmission. Disposable diapers should be used, and soiled diapers should be placed in a plastic bag before discarding. Feces can be flushed down the toilet. Hands should be washed after exposure to blood and body fluids and before caring for another child. Gloves should be worn if open sores are present on the caretaker's hands. Any open sore on the infected child should also be covered.
- Blood and body fluids on surfaces should be cleaned with one part household bleach diluted in 10 parts water.
- The hygienic practices of an infected child may improve as the child matures, or they may deteriorate if the child's condition worsens. For these reasons, the need for a restricted environment should be re-evaluated regularly.
- Adoption and foster care agencies should consider screening for AIDS virus infection before a child is placed in a foster or adoptive home. Foster and adoptive parents should be aware that they will need to learn about special care for the child.
- There is no reason to screen all children before they begin school.
- The records of children with AIDS should be kept confidential. The number of people who are aware of the child's condition should be kept to the minimum needed to assure proper care of the child and to detect situations, such as a bleeding injury, that may present a potential for transmission.
- All educational and public health departments are strongly encouraged to inform parents, children, and educators about AIDS and its transmission.

More information about AIDS and AIDS-related illnesses can be obtained from—

- Your doctor.
- Your state or local health department.
- The Public Health Service's toll-free hotline: 1-800-342-AIDS.
- Your local chapter of the American Red Cross.

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Oct 1986

AIDS and Children

Information for Parents of School-age Children

1798

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Red Cross

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American Red Cross

Infórmate de lo que es el SIDA*

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*SIDA — Sindrome de Inmunodeficiencia Adquirida

AIDS
CONOZCA LA VERDAD
SIDA

¿Qué es el SIDA?

SIDA son las iniciales para el síndrome de inmunodeficiencia adquirida (o en inglés, acquired immune deficiency syndrome, AIDS). Es una enfermedad mortal causada por un virus que destruye la habilidad del cuerpo para combatir las enfermedades y además lesiona el cerebro. El SIDA no mata de por sí. Permite a otras infecciones y enfermedades invadir el cuerpo, y son estas infecciones y enfermedades las que pueden matar. Estas enfermedades por lo regular no atacan a las personas con capacidad normal para combatir infecciones. Por ejemplo, entre las enfermedades que atacan con mayor regularidad a los pacientes adultos del SIDA se incluyen una infección poco común de los pulmones conocida como pulmonía parasitaria (Pneumocystis carinii), y una forma poco común de cáncer conocida como el Sarcoma de Kaposis. Muchas de las personas afectadas por el SIDA sufren gran pérdida de peso, y algunas desarrollan desórdenes mentales. En la actualidad, no se conoce una cura para el SIDA ni existe vacuna alguna para prevenir la enfermedad. Nadie se ha recuperado del SIDA.

¿Qué causa el SIDA?

De acuerdo a los descubrimientos de los investigadores, la causa del SIDA es un virus conocido como el Virus de Inmunodeficiencia Humana (Human Immunodeficiency Virus, HIV). Este virus cambia la estructura de las células cuando las ataca. La infección con este virus puede llegar a causar el SIDA. También puede causar una condición menos severa conocida como Complejo Relacionado con el SIDA (AIDS Related Complex, ARC), comúnmente conocida como CRS. Muchas de las personas infectadas con el virus pueden desarrollar síntomas del SIDA o del CRS. Al quedar infectada, la persona puede verse y sentirse bien. Puede no saber siquiera que está infectada con el virus. La enfermedad puede tomar diez años o más para desarrollarse, o puede no desarrollarse nunca. Sin embargo, una vez que la persona contrae la infección, continúa infectada para el resto de su vida. Puede transmitir el virus a otras personas.

¿Cómo se contrae el SIDA?

No todas las personas corren peligro de contraer el SIDA. Y aún aquellas personas que corren este peligro pueden protegerse si son precavidas. De tí depende protegerte contra el SIDA. Aprende cómo se contrae la enfermedad, cómo protegerte — y cómo proteger a tus seres queridos.

El virus se transmite de tres maneras fundamentales:

- Al tener sexo con una persona infectada.
- Al compartir agujas hipodérmicas o jeringuillas con personas que usan heroína, cocaína, u otras drogas intravenosas.
- Si la madre está infectada con el virus del SIDA, los bebés pueden nacer con el virus.

La mayoría de los casos del SIDA han ocurrido entre homosexuales y bisexuales, entre personas que usan drogas intravenosas, y las parejas sexuales de éstas. En menor grado, se ha encontrado el virus del SIDA entre hemofílicos y personas que han recibido transfusiones de sangre.

Tanto mujeres y hombres (homosexuales o heterosexuales) pueden contraer el virus del SIDA. Puedes contraer el SIDA de una sola experiencia sexual. Tu riesgo de infección aumenta si tienes más de una pareja sexual.

Las parejas que no están infectadas, que no usan drogas intravenosas, y que hayan disfrutado por mucho tiempo de una relación de fidelidad mutua, teniendo sexo siempre con la misma persona, están protegidas del SIDA.

El virus del SIDA no se transmite por contacto casual.

¿Cuáles son los síntomas?

La mayoría de las personas infectadas con el virus del SIDA no muestran síntoma alguno y se sienten bien. Algunas desarrollan síntomas entre los que se incluyen:

- fiebre, incluyendo escalofríos por las noches.
- pérdida de peso sin razón aparente.
- hinchazón en los ganglios linfáticos del cuello, las axilas o la ingle.

- fatiga o cansancio.
- diarrea.
- manchas blancas o irritaciones poco comunes en la boca.

Estos síntomas también se presentan en muchas otras enfermedades. Pueden ser síntomas del SIDA sólo si no se sufre de alguna otra enfermedad. Si estos síntomas persisten por más de dos semanas debes visitar a un médico.

¿Se puede transmitir el virus del SIDA a través del contacto casual?

No. El virus del SIDA no se transmite por el contacto casual normal en el trabajo, la escuela o en el hogar. El virus **no** se transmite:

- al abrazar o estrechar la mano de una persona que padezca del SIDA o que haya contraído el virus
- al usar inodoros, lavamanos, bañeras, piscinas o albercas que hayan sido usados por una persona infectada con el virus del SIDA
- al estornudar, toser, o escupir una persona infectada con el virus
- al usar platos, utensilios, o comida que haya tocado una persona con el virus del SIDA.

El virus del SIDA no se contrae a través del contacto casual, diario, con personas infectadas. Esto ha sido documentado, en parte, por estudios realizados en cientos de hogares donde había casos de SIDA. Ni siquiera los niños que habían compartido botellas, camas, cepillos de dientes y utensilios con hermanos infectados contrajeron el virus.

¿Existe una prueba para determinar si se tiene el SIDA?

Existe una prueba para detectar si se tienen anticuerpos contra el virus del SIDA. Cada vez que un virus o bacteria invade el cuerpo, éste produce anticuerpos para combatirlos. El cuerpo puede tardar algún tiempo para desarrollar anticuerpos al virus del SIDA.

A la mayoría de las personas les toma varias semanas o hasta varios meses. La prueba no puede detectar la infección con el virus del SIDA mientras no aparecen los anticuerpos. Cuando aparecen los anticuerpos, la prueba demuestra que la persona está infectada con el virus del SIDA.

¿Qué significa un resultado positivo?

Significa que la persona ha contraído el virus del SIDA y que puede transmitir la enfermedad a otros. Se calcula que entre un millón y un millón y medio de personas en los Estados Unidos han contraído el virus del SIDA. Muchas de estas personas desarrollarán el SIDA. Otras personas se verán saludables y no mostrarán síntoma alguno a pesar de estar infectadas, pero pueden transmitir el virus a otros a través del contacto sexual, y al compartir agujas hipodérmicas y jeringuillas. Las madres infectadas pueden transmitir el virus a sus bebés durante el embarazo o el alumbramiento.

¿Por qué tenemos un examen?

Este examen se usó por primera vez en los centros de donación de sangre para impedir que sangre contaminada con el virus del SIDA se mezclara y contaminara el resto de la sangre almacenada en los bancos de sangre. Siempre se han usado exámenes para asegurarse de que el suministro de sangre se mantenga tan seguro como sea posible. Por ejemplo, los bancos de sangre y los centros de donación examinan toda la sangre para prevenir la propagación del virus B de la hepatitis.

¿Es seguro el suministro de sangre?

El abastecimiento de sangre está muy bien protegido contra el virus del SIDA. Se les pide a las personas en peligro de contraer el virus de no donar sangre. Por ejemplo, a los hombres que han tenido relaciones sexuales con otros hombres desde 1977 se les aconseja no donar sangre. Además, la prueba se usa para detectar trazas del virus del SIDA en toda la sangre y plasma donado.

¿Me puedo contagiar yo al donar sangre?

No. Todas las agujas hipodérmicas, jeringuillas, tubos y envases usados en los centros de donación de sangre son esterilizados. Se usan solamente una vez y luego se descartan, por lo cual no hay posibilidad de infección.

¿Está disponible la prueba al público?

Sí. La prueba está disponible en muchos lugares en la mayoría de los estados. También está disponible a través de médicos y clínicas privadas. Puedes obtener información sobre dónde hacerte la prueba en el departamento de salud local, en las clínicas de enfermedades venéreas, en los consultorios de médicos, en los capítulos de la Cruz Roja Americana, en los bancos de sangre y en las organizaciones comunitarias de servicio contra el SIDA. Se recomienda a las personas que planeen hacerse el examen de informarse antes para entender el posible significado de los resultados. Es importante acudir a un consejero bien informado antes y después de la prueba.

¿Cómo me puedo proteger contra el SIDA?

El Servicio de Salud Pública recomienda las siguientes precauciones:

- No tengas relaciones sexuales con personas que padezcan del SIDA o con personas que obtengan un resultado positivo en la prueba del SIDA. Si tienes relaciones de todas maneras, usa un condón de látex con un espermicida que contenga al menos 6.5 miligramos de un agente químico conocido en inglés como "nonoxynol-9." No obstante, recuerda que los condones no son 100 por ciento seguros. Evita prácticas sexuales tales como el sexo anal que puede lesionar los tejidos.

- No uses drogas intravenosas. Si lo haces de todas maneras, no uses las agujas hipodérmicas o las jeringuillas de otras personas. Tampoco tengas relaciones sexuales con personas que usen drogas intravenosas.
- Las mujeres que tengan relaciones sexuales con hombres que practiquen conductas de alto riesgo, o que usen drogas intravenosas deben considerar los riesgos a sus criaturas antes de quedar embarazadas. Estas mujeres deberán hacerse la prueba de anticuerpos del HIV antes de quedar embarazadas. Si quedan embarazadas, deberán hacerse la prueba y ver a un consejero durante el embarazo.
- Evita las relaciones sexuales con muchas personas, incluyendo prostitutas (quienes además podrían usar drogas intravenosas). Mientras más sean las personas con las cuales tengas relaciones sexuales, mayor será tu posibilidad de contraer el SIDA. Si tú o tu pareja tienen relaciones sexuales con otras personas, pueden reducir el riesgo al usar condones de látex y un espermicida con "nonoxynol-9."

¿Qué puedo hacer si al hacerme la prueba obtengo resultados positivos?

- Házte un examen médico completo y recibe orientación adecuada.
- No dones sangre, ni sémen, ni órganos.
- No pongas en peligro a otras personas al tener relaciones sexuales con ellas o al compartir agujas o jeringuillas.
- No compartas cepillos de dientes, navajas de afeitar, ni ningún otro objeto que pueda estar contaminado con sangre.
- Trata de posponer el embarazo.

Puedes obtener más información sobre el SIDA en el capítulo de la Cruz Roja, en el departamento de salud local o estatal, en otras agencias de servicios a la comunidad, la agencia afiliada a la Red Nacional Contra el SIDA (National AIDS Network), o a través de la línea telefónica directa del SIDA. El número telefónico es 1-800-342-AIDS.

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El American Council of Life Insurance y la Health Insurance Association of America contribuyeron parcialmente a la preparación de este folleto.

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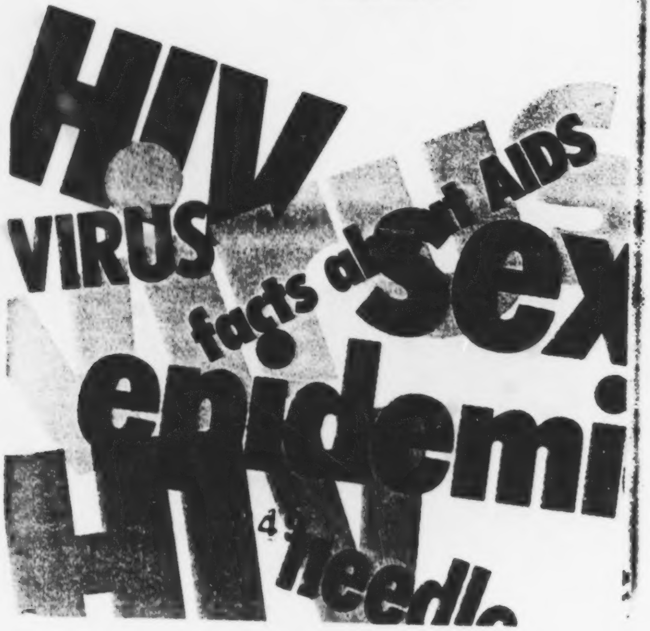
SCHOOL SYSTEMS AND AIDS: INFORMATION FOR TEACHERS AND SCHOOL OFFICIALS

American
Red Cross


HIV
VIRUS
facts about AIDS
sex
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needle

Health education for our youth is the most effective weapon against and is critical in preventing the spread of HIV/AIDS*. When young people know the facts about HIV infection and AIDS, they can take steps to protect themselves and those they care about. Schools play an important role in communities and in the lives of people who will eventually be affected directly or indirectly by HIV/AIDS. As an educator, it is important for you to know the facts about HIV infection and AIDS. Accurate information will help you to plan and implement effective policies and programs. Young people and school personnel must understand how to avoid becoming infected with the AIDS virus (HIV);* as well as how to respond to people who are infected.

What do I need to know about HIV infection and AIDS?

AIDS stands for *acquired immunodeficiency syndrome*. It is a disease caused by the human immunodeficiency virus (HIV)—the virus that causes AIDS. The AIDS virus (HIV) may live in the human body for years and can be spread to others before any symptoms appear. It primarily affects you by making your body unable to fight diseases and infections. These diseases and infections can kill you.

It is important to understand that people infected with the AIDS virus (HIV) usually look and feel healthy, and may not even know for many years that they are infected. When symptoms do appear, they can be like those of many common illnesses, such as a swollen glands, coughing, fever, or diarrhea. These symptoms vary from person to person. Only a doctor and a blood test can tell if someone is infected with the AIDS virus (HIV).

AIDS cannot be cured. Scientists expect that, if it is even possible, finding a vaccine or cure will take many more years of research.

Scientists estimate that 1.0 to 1.5 million people are currently infected with the AIDS virus (HIV). Most of these people appear healthy today. By 1992, as many as 365,000 of these people will have been diagnosed with AIDS. In that year alone, as many as 66,000 people will die from AIDS.

How is the AIDS virus (HIV) spread?

Here are the most common ways the AIDS virus (HIV) is spread:

► Unprotected sex (vaginal or anal intercourse and oral sex without a condom and spermicide) with someone who is infected with the AIDS virus (HIV)

► Sharing drug needles or syringes with someone who is infected with the AIDS virus (HIV)

► From infected mother to baby during pregnancy or childbirth and possibly by breast feeding

Some people became infected with the AIDS virus (HIV) through infected blood and certain blood products (used for transfusion and to treat diseases like hemophilia). The chance of becoming infected with the AIDS virus (HIV) through transfusion in the United States is now extremely low. Donated blood and plasma have been tested for antibodies to

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*The virus that causes AIDS and related disorders is named *human immunodeficiency virus* (HIV). In the past, it was called HTLV-III, LAV, or ARV. Now scientists all over the world refer to the AIDS virus as HIV.

the AIDS virus (HIV) since spring 1985. In addition, those who want to give blood have been screened out (not allowed to give blood) if they indicate that they are at risk of being infected with certain germs, including the AIDS virus (HIV).

If antibodies to the AIDS virus (HIV) are found in donated blood, the blood is destroyed. However, the test cannot completely eliminate all infected blood. This is because it is possible for people to donate blood or plasma shortly after becoming infected unknowingly with the AIDS virus (HIV), or before their blood has produced antibodies that can be found by current blood tests. Although the current blood tests are very accurate, more specific and accurate tests are being developed to make blood and plasma products even safer.

Health care workers who take care of people with AIDS have been studied for several years. Studies in this country, England, and Canada have shown that fewer than one percent of these workers who were stuck accidentally by infected needles and sharp objects became infected with the AIDS virus (HIV).

Are children safe from HIV/AIDS at school?

Yes.

Scientific studies from around the world have shown how the AIDS virus (HIV) is and is not spread.

They show that children will not get HIV/AIDS from—

- Playing with other children.
- Touching other children.
- Coughing, sneezing, or spitting.
- Drinking fountains.
- A hug.
- A closed-mouth kiss.
- Sweat or tears.
- Mosquitoes or other insects.
- Eating food prepared or served by someone who is infected with the virus.

or from using—

- Toilet or shower facilities.
- Forks, knives, spoons, or cups.
- Chairs, desks, tools, or phones.
- Playground equipment and swimming pools.

Scientific studies have shown that even family members living with a person who has AIDS do not become infected with the AIDS virus (HIV). Family members across the nation help their loved ones eat, bathe, and dress without becoming infected. Children even share spoons and cups and do not become infected.

How do children get HIV Infection/AIDS?

Most children under the age of 13 became infected from their infected mothers during pregnancy or during birth. Infected women have been shown to pass the virus to their babies as much as 50 percent of the time. The virus may also be passed to the baby by breast milk from an infected mother. Most babies born infected become sick and die before the age of three.

Some children became infected with the AIDS virus (HIV) from infected blood transfusions and certain blood products. This is now extremely rare. Like adults, teens can get HIV infection/AIDS by having sex or by sharing drug needles or syringes with an infected person.

Children and teens can also become infected through sexual abuse. If you know of a child who is being abused, call the National Child Abuse Hot Line (toll free): 1-800-422-4453.

There have been no cases of young children getting HIV infection/AIDS from playing with other children who are infected the AIDS virus (HIV).

Students and school personnel will not become infected with the AIDS virus (HIV) through everyday school activities with a school employee who is infected.

What if I have a student who is infected with the AIDS virus (HIV)?

A student who is infected with the AIDS virus (HIV) does not pose any health risk to other students or school personnel in school and after-school day care. Don't avoid the child with HIV/AIDS. Include him or her in activities whenever possible. Like anyone else, the child may feel anger, frustration, and depression.

Decisions about education and care for a child infected with the AIDS virus (HIV) should be made by a team that includes the child's parents or guardian, physician, public health personnel, and school officials. It is important to help make attending school a positive and rewarding experience for the student with HIV/AIDS. The need for a more restricted environment should be reevaluated regularly in the event that the child's condition worsens.

Who should be informed about a student with HIV infection/AIDS?

The records of children who are infected with the AIDS virus (HIV) should be kept confidential. The number of people who are aware of the child's condition should be kept to the minimum needed to ensure proper care of the child.

The Privacy Act, which applies to government agencies, forbids anyone from revealing medical information without that person's consent. Since AIDS is not spread through everyday school activities, it is not necessary to inform other students or parents that a specific child is infected. If a student's diagnosis is discovered by other students, you can help by stopping rumors and correcting misinformation about how the AIDS virus (HIV) is spread.

Schools should develop an effective AIDS policy that is responsive to the concerns of parents of both infected and uninfected students.

Is attending school safe for children who have HIV/AIDS?

Any child who has a damaged immune system may risk suffering complications from infections that may be spread in school or day care settings. Prompt medical attention is advised if there is a possibility that the child with HIV/AIDS has been exposed to any serious infection. Exposure to chickenpox or shingles (herpes zoster) can be very serious. If the child with HIV/AIDS is exposed to a child with chickenpox or an adult with shingles, contact the child's parents and doctor (preferably within 24 hours) because there is a special medicine which, if given promptly, may help to prevent chickenpox in the child with HIV/AIDS.

Returning to school after an AIDS-related illness can be an important part of a child's recovery process. The child's doctor should evaluate any health risks involved in school attendance, based on the child's medical history and current health status.

What about giving first aid or CPR in school settings?

School employees should observe the school's safety policy when giving first aid or CPR to reduce the risk of becoming infected with any disease. School employees can learn more about first aid and CPR by taking a course from the Red Cross.

All personnel in schools and day care facilities should follow standard infection control precautions. This means wearing latex or vinyl gloves when there is the possibility of contact with any person's blood. Blood on surfaces should be cleaned with a hospital-grade disinfectant solution. If a disinfectant is not available, you can make one by mixing one cup of liquid household chlorine bleach in nine cups of water. (This solution must be made fresh just prior to its use and discarded each day.) Wash your hands with soap and water after touching blood, even if you were wearing gloves.

Scientific studies do not indicate any risk of spread of the AIDS virus (HIV) from contact with stool (feces), nasal fluid, spit (saliva), sweat, tears, urine, or vomit, unless these fluids contain visible blood.

What about school employees who have HIV infection or AIDS?

Students and school personnel will not become infected with the AIDS virus (HIV) through everyday school activities with a school employee who is infected. School employees who have HIV infection or AIDS should be allowed to continue working as long as they are able.

Your school district should have an effective AIDS policy for infected and uninfected school employees. Laws regarding confidentiality of employees' medical records apply to school personnel. There may also be specific state laws that you should become aware of.

AIDS education programs geared toward parents and the community can help decrease unnecessary fears about school employees who have AIDS.

Public Health Service recommendations for curriculum development

The specific scope and content of AIDS education for students should be locally determined and consistent with parental and community values. Broad community participation will ensure that school AIDS education policies and programs reflect local values. In general—

► Education about AIDS for students in early elementary grades should be designed to reduce unnecessary fear of the epidemic and fear of becoming infected.

► Education about AIDS for students in late elementary/middle school grades should provide students with basic facts about the nature of viruses and the ways the AIDS virus (HIV) is transmitted.

► Education about AIDS for students in junior high/senior high school grades should provide basic facts about the AIDS virus (HIV) and HIV infection/AIDS transmission and prevention.

Recommendations for HIV/AIDS education for school personnel and parents

All school personnel and relevant groups, such as parent groups, school physicians, and school board personnel, should receive general training and continuing education about—

► The most current information about controlling the HIV infection/AIDS epidemic, including personal risk behaviors and prevention.

► The role of the school in providing education about the epidemic.

► Up-to-date information about the most effective health education interventions.

► School policies for students and staff who may be infected.

Is the relevant program included as an important part of a more comprehensive school health education program?

The role of the schools in responding to the HIV/AIDS epidemic

The following criteria were adapted from "Guidelines for Effective School Health Education to Prevent the Spread of AIDS" (Centers for Disease Control [CDC], *Morbidity and Mortality Weekly Report*, January 29, 1988, vol. 37, S-2). These guidelines incorporate principles for AIDS education that were developed by the President's Domestic Policy Council and approved by the President in 1987.

Criteria for an effective school health education program on HIV/AIDS

Read through the list and try to answer each question with your own school or school district in mind:

Yes No

☐ ☐ Are parents, teachers, students, and appropriate community representatives involved in developing, implementing, and assessing AIDS education policies and programs?

☐ ☐ Is the relevant program included as an important part of a more comprehensive school health education program?

☐ ☐ Is the program taught by regular classroom teachers in elementary grades and by qualified health education teachers or other similarly trained personnel in secondary grades?

☐ ☐ Is the program designed to help students at each appropriate grade learn essential facts to prevent the spread of the AIDS virus (HIV)?

☐ ☐ Does the program describe the benefits of avoiding sex for young people and mutually monogamous relationships within the context of marriage?

☐ ☐ Is the program designed to help teenage students avoid specific types of behavior that increase the risk of becoming infected with the AIDS virus (HIV)?

☐ ☐ Is adequate training about AIDS provided for school administrators, teachers, nurses, and counselors—especially those who teach about AIDS?

☐ ☐ Are sufficient program development time, classroom time, and educational materials provided for education about AIDS?

☐ ☐ Are the processes and outcomes of AIDS education being monitored and periodically assessed?

The extent to which these criteria are being met can be used as a measure of school progress toward effective health education about AIDS. If you answered "yes" to all of these criteria, your programs are close to meeting the CDC guidelines for effective school health education on AIDS. If you answered "no" to most of these questions, you may want to seek assistance for your school district from other school districts, educational associations, health departments, or a Red Cross chapter as you begin to develop your own AIDS education programs and policies.

If you answered "yes" to some and "no" to others, you know you have some areas that need improvement and others where you have achieved some successes. Please keep up the good work. There is so much that needs to be done.

What can I do to help?

Know the facts about HIV infection and AIDS. Use what you know to protect yourself. Teach your family, friends, and co-workers about HIV/AIDS.

Set a compassionate example for others. Show support and understanding for people who are infected with HIV and for those who have AIDS.

Teach children compassion. Your students may know someone who is infected with HIV or who has AIDS. Remember, you can't get HIV/AIDS by being a friend.

Encourage HIV/AIDS education in your school. Contact the Red Cross for information on HIV/AIDS education programs for school-age children.

Become a volunteer. Call your local Red Cross or AIDS service organization to learn how you can help.

Sponsor a blood drive through your school or donate blood. (Make sure you meet donor requirements before donating blood.) This is one way to let others know that *it is impossible* *for a donor to get HIV infection/AIDS by donating blood.* Blood donations from healthy volunteers save lives.

Sponsor an HIV/AIDS fund-raising event or donate money.

For more information, contact:

- Your local chapter of the American Red Cross.
- The National AIDS Information Hot Line (toll free): 1-800-342-AIDS. For Spanish-speaking persons, Linea Nacional de SIDA: 1-800-344-SIDA. For hearing-impaired persons, TTY/TDD Hot Line: 1-800-AIDS-TTY.
- Your local, state, or national PTA (Parent Teacher Association).
- Your doctor or health care worker.
- Your local or state public health department.
- Your local AIDS service organization.

Other Red Cross brochures

- *AIDS: The Facts*
- *Children, Parents, and AIDS*
- *Drugs, Sex, and AIDS*
- *Men, Sex, and AIDS*
- *Teenagers and AIDS*
- *Women, Sex, and AIDS*
- *Your Job and AIDS: Are There Risks?*

Other Red Cross programs and materials

- AIDS Prevention Program for Youth (Student Workbook, Teacher's/Leader's Guide; three videos: *A Letter From Brian, Don't Forget Sherrie,* and *Answers About AIDS* and video discussion guides)
- AIDS Prevention Program for the Workplace
- Award-winning documentary, *Beyond Fear*

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Foreword

October 22, 1986

This is a report from the Surgeon General of the U.S. Public Health Service to the people of the United States on AIDS. Acquired Immune Deficiency Syndrome is an epidemic that has already killed thousands of people, mostly young, productive Americans. In addition to illness, disability, and death, AIDS has brought fear to the hearts of most Americans — fear of disease and fear of the unknown. Initial reporting of AIDS occurred in the United States, but AIDS and the spread of the AIDS virus is an international problem. This report focuses on prevention that could be applied in all countries.

My report will inform you about AIDS, how it is transmitted, the relative risks of infection and how to prevent it. It will help you understand your fears. Fear can be useful when it helps people avoid behavior that puts them at risk for AIDS. On the other hand, unreasonable fear can be as crippling as the disease itself. If you are participating in activities that could expose you to the AIDS virus, this report could save your life.

In preparing this report, I consulted with the best medical and scientific experts this country can offer. I met with leaders of organizations concerned with health, education, and other aspects of our society to gain their views of the problems associated with AIDS. The information in this report is current and timely.

This report was written personally by me to provide the necessary understanding of AIDS.

The vast majority of Americans are against illicit drugs. As a health officer I am opposed to the use of illicit drugs. As a practicing physician for more than forty years, I have seen the devastation that follows the use of illicit drugs – addiction, poor health, family disruption, emotional disturbances and death. I applaud the President's initiative to rid this nation of the curse of illicit drug use and addiction. The success of his initiative is critical to the health of the American people and will also help reduce the number of persons exposed to the AIDS virus.

Some Americans have difficulties in dealing with the subjects of sex, sexual practices, and alternate lifestyles. Many Americans are opposed to homosexuality, promiscuity of any kind, and prostitution. This report must deal with all of these issues, but does so with the intent that information and education can change individual behavior, since this is the primary way to stop the epidemic of AIDS. This report deals with the positive and negative consequences of activities and behaviors from a health and medical point of view.

Adolescents and pre-adolescents are those whose behavior we wish to especially influence because of their vulnerability when they are exploring their own sexuality (heterosexual and homosexual) and perhaps experimenting with drugs. Teenagers often consider themselves immortal, and these young people may be putting themselves at great risk.

Education about AIDS should start in early elementary school and at home so that children can grow up knowing the behavior to avoid to protect themselves from exposure to the AIDS virus. The threat of AIDS can provide an opportunity for parents to instill in their children their own moral and ethical standards.

Those of us who are parents, educators and community leaders, indeed all adults, cannot disregard this responsibility to educate our young. The need is critical and the price of neglect is high. The lives of our young people depend on our fulfilling our responsibility.

AIDS is an infectious disease. It is contagious, but it cannot be spread in the same manner as a common cold or measles or chicken pox. It is contagious in the same way that sexually transmitted diseases, such as syphilis and gonorrhea, are contagious. AIDS can also be spread through the sharing of intravenous drug needles and syringes used for injecting illicit drugs.

AIDS is *not* spread by common everyday contact but by sexual contact (penis-vagina, penis-rectum, mouth-rectum, mouth-vagina, mouth-penis). Yet there is great misunderstanding resulting in unfounded fear that AIDS can be spread by casual, non-sexual contact. The first cases of AIDS were reported in this country in 1981. We would know by now if AIDS were passed by casual, non-sexual contact.

Today those practicing high risk behavior who become infected with the AIDS virus are found mainly among homosexual and bisexual men and male and female intravenous drug users. Heterosexual transmission is expected to account for an increasing proportion of those who become infected with the AIDS virus in the future.

At the beginning of the AIDS epidemic many Americans had little sympathy for people with AIDS. The feeling was that somehow people from certain groups "deserved" their illness. Let us put those feelings behind us. We are fighting a disease, not people. Those who are already afflicted are sick people and need our care as do all sick patients. The country must face this epidemic as a unified society. We must prevent the spread of AIDS while at the same time preserving our humanity and intimacy.

AIDS is a life-threatening disease and a major public health issue. Its impact on our society is and will continue to be devastating. By the end of 1991, an estimated 270,000 cases of AIDS will have occurred with 179,000 deaths within the decade since the disease was first recognized. In the year 1991, an estimated 145,000 patients with AIDS will need health and supportive services at a total cost of between $8 and $16 billion. However, AIDS is preventable. It can be controlled by changes in personal behavior. It is the responsibility of every citizen to be informed about AIDS and to exercise the appropriate preventive measures. This report will tell you how.

The spread of AIDS can and must be stopped.

C Everett Koop

C. Everett Koop, M.D., Sc.D.
Surgeon General

AIDS

AIDS Caused by Virus

The letters A-I-D-S stand for Acquired Immune Deficiency Syndrome. When a person is sick with AIDS, he/she is in the final stages of a series of health problems caused by a virus (germ) that can be passed from one person to another chiefly during sexual contact or through the sharing of intravenous drug needles and syringes used for "shooting" drugs. Scientists have named the AIDS virus "HIV or HTLV-III or LAV"[1]. These abbreviations stand for information denoting a virus that attacks white blood cells (T-Lymphocytes) in the human blood. Throughout this publication, we will call the virus the "AIDS virus." The

Artists drawing of AIDS virus with cut away view showing genetic (reproductive) material.

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[1] These are different names given to AIDS virus by the scientific community:

HIV — Human Immunodeficiency Virus
HTLV-III — Human T-Lymphotropic Virus Type III
LAV — Lymphadenopathy Associated Virus

AIDS virus attacks a person's immune system and damages his/her ability to fight other disease. Without a functioning immune system to ward off other germs, he/she now becomes vulnerable to becoming infected by bacteria, protozoa, fungi, and other viruses and malignancies, which may cause life-threatening illness, such as pneumonia, meningitis, and cancer.

No Known Cure

There is presently no cure for AIDS. There is presently no vaccine to prevent AIDS.

Virus Invades Blood Stream

When the AIDS virus enters the blood stream, it begins to attack certain white blood cells (T-Lymphocytes). Substances called antibodies are produced by the body. These antibodies can be detected in the blood by a simple test, usually two weeks to three months after infection. Even before the antibody test is positive, the victim can pass the virus to others by methods that will be explained.

Once an individual is infected, there are several possibilities. Some people may remain well but even so they are able to infect others. Others may develop a disease that is less serious than AIDS referred to as AIDS Related Complex (ARC). In some people the protective immune system may be destroyed by the virus and then other germs (bacteria, protozoa, fungi and other viruses) and cancers that ordinarily would never get a foothold cause "opportunistic diseases" — using the *opportunity* of lowered resistance to infect and destroy. Some of the most common are *Pneumocystis carinii* pneumonia and tuberculosis. Individuals infected with the AIDS virus may also develop certain types of cancers such as Kaposi's sarcoma. These infected people have classic AIDS. Evidence shows that the AIDS virus may also attack the nervous system, causing damage to the brain.

Signs and Symptoms

No Signs

Some people remain apparently well after infection with the AIDS virus. They may have no physically apparent symptoms of illness. However, if proper precautions are not used with sexual contacts and/or intravenous drug use, these infected individuals can spread the virus to others. Anyone who thinks he or she is infected or involved in high risk behaviors should not donate his/her blood, organs, tissues, or sperm because they may now contain the AIDS virus.

ARC

AIDS-Related Complex (ARC) is a condition caused by the AIDS virus in which the patient tests positive for AIDS infection and has a specific set of clinical symptoms. However, ARC patients' symptoms are often less severe than those with the disease we call classic AIDS. Signs and symptoms of ARC may include loss of appetite, weight loss, fever, night sweats, skin rashes, diarrhea, tiredness, lack of resistance to infection, or swollen lymph nodes. These are also signs and symptoms of many other diseases and a physician should be consulted.

AIDS

Only a qualified health professional can diagnose AIDS, which is the result of a natural progress of infection by the AIDS virus. AIDS destroys the body's immune (defense) system and allows otherwise controllable infections to invade the body and cause additional diseases. These opportunistic diseases would not otherwise gain a foothold in the body. These opportunistic diseases may eventually cause death.

Some symptoms and signs of AIDS and the "opportunistic infections" may include a persistent cough and fever associated with shortness of breath or difficult breathing and may be the symptoms of *Pneumocystis carinii* pneumonia. Multiple purplish blotches and bumps on the skin may be a sign of Kaposi's sarcoma. The AIDS virus in all infected people is essentially the same; the reactions of individuals may differ.

Long Term

The AIDS virus may also attack the nervous system and cause delayed damage to the brain. This damage may take years to develop and the symptoms may show up as memory loss, indifference, loss of coordination, partial paralysis, or mental disorder. These symptoms may occur alone, or with other symptoms mentioned earlier.

AIDS: the present situation

The number of people estimated to be infected with the AIDS virus in the United States is about 1.5 million. All of these individuals are assumed to be capable of spreading the virus sexually (heterosexually or homosexually) or by sharing needles and syringes or other implements for intravenous drug use. Of these, an estimated 100,000 to 200,000 will come down with AIDS Related Complex (ARC). It is difficult to predict the number who will develop ARC or AIDS because symptoms sometimes take as long as nine years to show up. With our present knowledge, scientists predict that 20 to 30 percent of those infected with the AIDS virus will develop an illness that fits an accepted definition of AIDS within five years. The number of persons known to have AIDS in the United States to date is over 25,000; of these, about half have died of the disease. Since there is no cure, the others are expected to also eventually die from their disease.

The majority of infected antibody positive individuals who carry the AIDS virus show no disease symptoms and may not come down with the disease for many years, if ever.

No Risk from Casual Contact

There is no known risk of non-sexual infection in most of the situations we encounter in our daily lives. We know that family members living with individuals who have the AIDS virus do not become infected except through sexual contact. There is no evidence of transmission (spread) of AIDS virus by everyday contact even though these family members shared food, towels, cups, razors, even toothbrushes, and kissed each other.

Health Workers

We know even more about health care workers exposed to AIDS patients. About 2,500 health workers who were caring for AIDS patients when they were sickest have been carefully studied and tested for infection with the AIDS virus. These doctors, nurses and other health care givers have been exposed to the AIDS patients' blood, stool and other body fluids. Approximately 750 of these health workers reported possible additional exposure by direct contact with a patient's body fluid through spills or being accidentally stuck with a needle. Upon testing these 750, only 3 who had accidentally stuck themselves with a needle had a positive antibody test for exposure to the AIDS virus. Because health workers had much more contact with patients and their body fluids than would be expected from common everyday contact, it is clear that the AIDS virus is not transmitted by casual contact.

Control of Certain Behaviors Can Stop Further Spread of AIDS

Knowing the facts about AIDS can prevent the spread of the disease. Education of those who risk infecting themselves or infecting other people is the only way we can stop the spread of AIDS. People must be responsible about their sexual behavior and must avoid the use of illicit intravenous drugs and needle sharing. We will describe the types of behavior that lead to infection by the AIDS virus and the personal measures that must be taken for effective protection. If we are to stop the AIDS epidemic, we all must understand the disease – its cause, its nature, and its prevention. *Precautions must be taken.* The AIDS virus infects persons who expose themselves to known risk behavior, such as certain types of homosexual and heterosexual activities or sharing intravenous drug equipment.

Risks

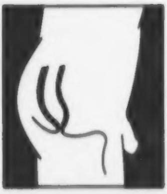
Although the initial discovery was in the homosexual community, AIDS is not a disease only of homosexuals. AIDS is found in heterosexual people as well. AIDS is not a black or white disease. AIDS is not just a male disease. AIDS is found in women; it is found in children. In the future AIDS will probably increase and spread among people who are not homosexual or intravenous drug abusers in the same manner as other sexually transmitted diseases like syphilis and gonorrhea.

Sex Between Men

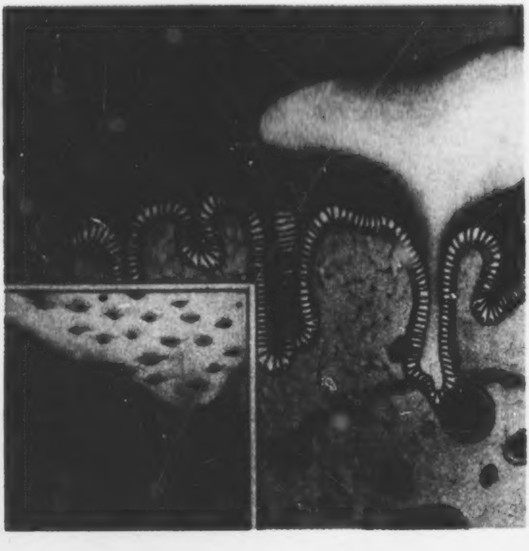
Men who have sexual relations with other men are especially at risk. About 70 percent of AIDS victims throughout the country are male homosexuals and bisexuals. This percentage probably will decline as heterosexual transmission increases. *Infection results from a sexual relationship with an infected person.*

Multiple Partners

The risk of infection increases according to the number of sexual partners one has, *male or female.* The more partners you have, the greater the risk of becoming infected with the AIDS virus.



Vulnerable rectum lining provides avenue for entry of AIDS virus into the blood stream.



How Exposed

Although the AIDS virus is found in several body fluids, a person acquires the virus during sexual contact with an infected person's blood or semen and possibly vaginal secretions. The virus then enters a person's blood stream through their rectum, vagina or penis.

Small (unseen by the naked eye) tears in the surface lining of the vagina or rectum may occur during insertion of the penis, fingers, or other objects, thus opening an avenue for entrance of the virus directly into the blood stream; therefore, the AIDS virus can be passed from penis to rectum and vagina and vice versa without a visible tear in the tissue or the presence of blood.

Prevention of Sexual Transmission – Know Your Partner

Couples who maintain mutually faithful monogamous relationships (only one continuing sexual partner) are protected from AIDS through sexual transmission. If you have been faithful for at least five years and your partner has been faithful too, neither of you is at risk. If you have not been faithful, then you and your partner are at risk. If your partner has not been faithful, then your partner is at risk which also puts you at risk. This is true for both heterosexual and homosexual couples. Unless it is possible to know with ***absolute certainty*** that neither you nor your sexual partner is carrying the virus of AIDS, you must use protective behavior. ***Absolute certainty*** means not only that you and your partner have maintained a mutually faithful monogamous sexual relationship, but it means that neither you nor your partner has used illegal intravenous drugs.

AIDS: you can protect yourself from infection

Some personal measures are adequate to safely protect yourself and others from infection by the AIDS virus and its complications. Among these are:

- If you have been involved in any of the high risk sexual activities described above or have injected illicit intravenous drugs into your body, you should have a blood test to see if you have been infected with the AIDS virus.

- If your test is positive or if you engage in high risk activities and choose not to have a test, you should tell your sexual partner. If you jointly decide to have sex, you must protect your partner by always using a rubber (condom) during (start to finish) sexual intercourse (vagina or rectum).

- If your partner has a positive blood test showing that he/she has been infected with the AIDS virus or you suspect that he/she has been exposed by previous heterosexual or homosexual behavior or use of intravenous drugs with shared needles and syringes, a rubber (condom) should always be used during (start to finish) sexual intercourse (vagina or rectum).

- If you or your partner is at high risk, avoid mouth contact with the penis, vagina, or rectum.
- Avoid all sexual activities which could cause cuts or tears in the linings of the rectum, vagina, or penis.
- Single teen-age girls have been warned that pregnancy and contracting sexually transmitted diseases can be the result of only one act of sexual intercourse. They have been taught to say *NO* to sex! They have been taught to say *NO* to drugs! By saying *NO* to sex and drugs, they can avoid AIDS which can *kill* them! The same is true for teenage boys who should also not have rectal intercourse with other males. It may result in AIDS.
- Do not have sex with prostitutes. Infected male and female prostitutes are frequently also intravenous drug abusers; therefore, they may infect clients by sexual intercourse and other intravenous drug abusers by sharing their intravenous drug equipment. Female prostitutes also can infect their unborn babies.

Dirty intravenous needle and syringe contaminated with blood that may contain the AIDS virus.

Intravenous Drug Users

Drug abusers who inject drugs into their veins are another population group at high risk and with high rates of infection by the AIDS virus. Users of intravenous drugs make up 25 percent of the cases of AIDS throughout the country. The AIDS virus is carried in contaminated blood left in the needle, syringe, or other drug related implements and the virus is injected into the new victim by reusing dirty syringes and needles. Even the smallest amount of infected blood left in a used needle or syringe can contain live AIDS virus to be passed on to the next user of those dirty implements.

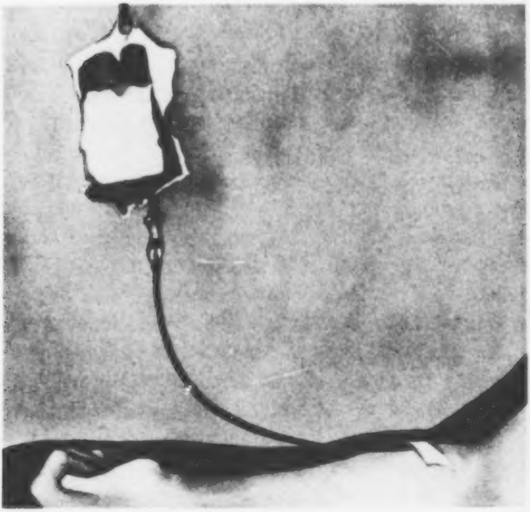
No one should shoot up drugs because addiction, poor health, family disruption, emotional disturbances and death could follow. However, many drug users are addicted to drugs and for one reason or another have not changed their behavior. For these people, the only way not to get AIDS is *to use a clean, previously unused* needle, syringe or any other implement necessary for the injection of the drug solution.

Hemophilia

Some persons with hemophilia (a blood clotting disorder that makes them subject to bleeding) have been infected with the AIDS virus either through blood transfusion or the use of blood products that help their blood clot. Now that we know how to prepare safe blood products to aid clotting, this is unlikely to happen. This group represents a very small percentage of the cases of AIDS throughout the country.

Blood Transfusion

Currently all blood donors are initially screened and blood is *not* accepted from high risk individuals. Blood that has been collected for use is tested for the presence of antibody to the AIDS virus. However, some people may have had a blood transfusion prior to March 1985 before we knew how to screen blood for safe transfusion and may have become



infected with the AIDS virus. Fortunately there are not now a large number of these cases. With routine testing of blood products, the blood supply for transfusion is now safer than it has ever been with regard to AIDS.

Persons who have engaged in homosexual activities or have shot street drugs within the last 10 years should *never* donate blood.

Mother Can Infect Newborn

If a woman is infected with the AIDS virus and becomes pregnant, she is more likely to develop ARC or classic AIDS, and she can pass the AIDS virus to her unborn child. Approximately one third of the babies born to AIDS-infected mothers will also be infected with the AIDS virus. Most of the infected babies will eventually develop the disease and die. Several of these babies have been born to wives of hemophiliac men infected with the AIDS virus by way of contaminated blood products. Some babies have also been born to women who became infected with the AIDS virus by bisexual partners who had the virus. Almost all babies with AIDS have been born to women who were intravenous drug users or the sexual partners of intravenous drug users who were infected with the AIDS virus. More such babies can be expected.

Think carefully if you plan on becoming pregnant. If there is any chance that you may be in any high risk group or that you have had sex with someone in a high risk group, such as homosexual and bisexual males, drug abusers and their sexual partners, see your doctor.

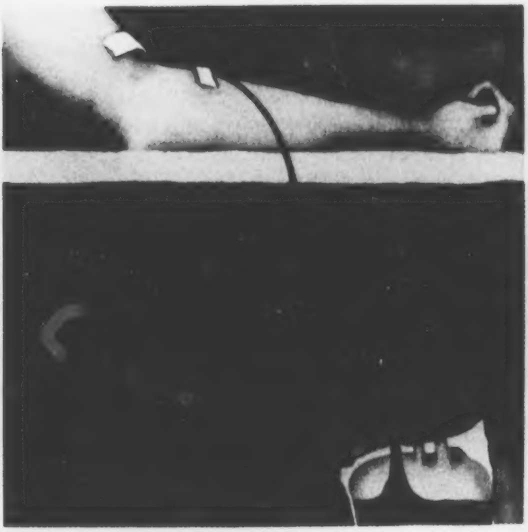
Summary

AIDS affects certain groups of the population. Homosexual and bisexual males who have had sexual contact with other homosexual or bisexual males as well as those who "shoot" street drugs are at greatest risk of exposure, infection and eventual death. Sexual partners of these high risk individuals are at risk, as well as any children born to women who carry the virus. Heterosexual persons are increasingly at risk.

AIDS: what is safe

Most Behavior is Safe

Everyday living does not present any risk of infection. You *cannot* get AIDS from casual social contact. Casual social contact should not be confused with casual *sexual* contact which is a major cause of the spread of the AIDS virus. Casual *social* contact such as shaking hands, hugging, social kissing, crying, coughing or sneezing, will not transmit the AIDS virus. Nor has AIDS been contracted from swimming in pools or bathing in hot tubs or from eating in restaurants (even if a restaurant worker has AIDS or carries the AIDS virus.) AIDS is not contracted from sharing bed linens, towels, cups, straws, dishes, or any other eating utensils. You cannot get AIDS from toilets, doorknobs, telephones, office machinery, or household furniture. You cannot get AIDS from body massages, masturbation or any non-sexual contact.



Donating Blood

Donating blood is *not* risky at all. *You cannot get AIDS by donating blood.*

Receiving Blood

In the U.S. every blood donor is screened to exclude high risk persons and every blood donation is now tested for the presence of antibodies to the AIDS virus. Blood that shows exposure to the AIDS virus by the presence of antibodies is not used either for transfusion or for the manufacture of blood products. Blood banks are as safe as current technology can make them. Because antibodies do not form immediately after exposure to the virus, a newly infected person may unknowingly donate blood after becoming infected but before his/her antibody test becomes positive. It is estimated that this might occur less than once in 100,000 donations.

There is no danger of AIDS virus infection from visiting a doctor, dentist, hospital, hairdresser or beautician. AIDS

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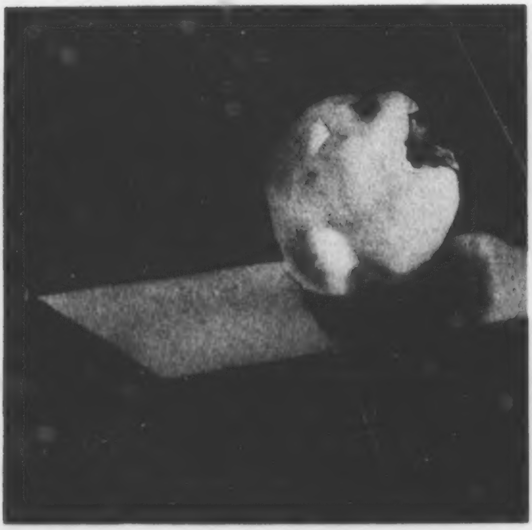
cannot be transmitted non-sexually from an infected person through a health or service provider to another person. Ordinary methods of disinfection for urine, stool and vomitus which are used for non-infected people are adequate for people who have AIDS or are carrying the AIDS virus. You may have wondered why your dentist wears gloves and perhaps a mask when treating you. This does not mean that he has AIDS or that he thinks you do. He is protecting you and himself from hepatitis, common colds or flu.

There is no danger in visiting a patient with AIDS or caring for him or her. Normal hygienic practices, like wiping of body fluid spills with a solution of water and household bleach (1 part household bleach to 10 parts water), will provide full protection.

Children in School

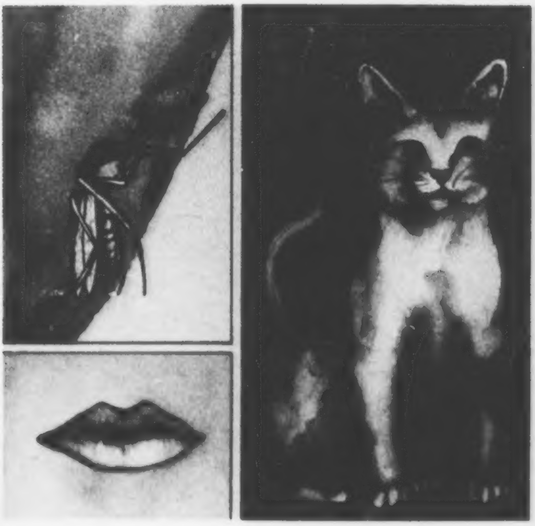
None of the identified cases of AIDS in the United States are known or are suspected to have been transmitted from one child to another in school, day care, or foster care settings. Transmission would necessitate exposure of open



cuts to the blood or other body fluids of the infected child, a highly unlikely occurrence. Even then routine safety procedures for handling blood or other body fluids (which should be standard for all children in the school or day care setting) would be effective in preventing transmission from children with AIDS to other children in school.

Children with AIDS are highly susceptible to infections, such as chicken pox, from other children. Each child with AIDS should be examined by a doctor before attending school or before returning to school, day care or foster care settings after an illness. No blanket rules can be made for all school boards to cover all possible cases of children with AIDS and each case should be considered separately and individualized to the child and the setting, as would be done with any child with a special problem, such as cerebral palsy or asthma. A good team to make such decisions with the school board would be the child's parents, physician and a public health official.

Casual social contact between children and persons infected with the AIDS virus is not dangerous.



Insects

There are no known cases of AIDS transmission by insects, such as mosquitoes.

Pets

Dogs, cats and domestic animals are not a source of infection from AIDS virus.

Tears and Saliva

Although the AIDS virus has been found in tears and saliva, no instance of transmission from these body fluids has been reported.

AIDS comes from sexual contacts with infected persons and from the sharing of syringes and needles. There is no danger of infection with AIDS virus by casual social contact.

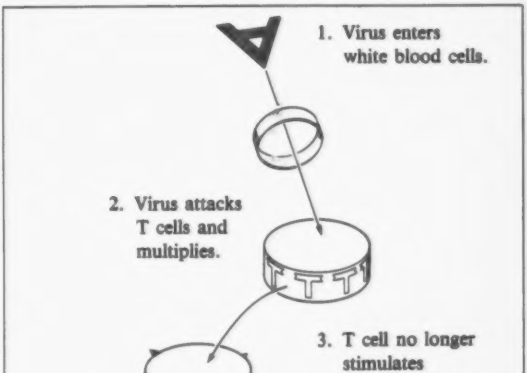
Testing of Military Personnel

You may wonder why the Department of Defense is currently testing its uniformed services personnel for presence of the AIDS virus antibody. The military feel this procedure is necessary because the uniformed services act as their own blood bank in a time of national emergency. They also need to protect new recruits (who unknowingly may be AIDS virus carriers) from receiving live virus vaccines. These vaccines could activate disease and be potentially life-threatening to the recruits.

AIDS: what is currently understood

Although AIDS is still a mysterious disease in many ways, our scientists have learned a great deal about it. In five years we know more about AIDS than many diseases that we have studied for even longer periods. While there is no vaccine or cure, the results from the health and behavioral research community can only add to our knowledge and increase our understanding of the disease and ways to prevent and treat it.

In spite of all that is known about transmission of the AIDS virus, scientists will learn more. One possibility is the


1. Virus enters white blood cells.
2. Virus attacks T cells and multiplies.
3. T cell no longer stimulates (cellular) defense response.
4. Immune system weakened.
5. Body susceptible to "opportunistic diseases."

potential discovery of factors that may better explain the mechanism of AIDS infection.

Why are the antibodies produced by the body to fight the AIDS virus not able to destroy that virus?

The antibodies detected in the blood of carriers of the AIDS virus are ineffective, at least when classic AIDS is actually triggered. They cannot check the damage caused by the virus, which is by then present in large numbers in the body. Researchers cannot explain this important observation. We still do not know why the AIDS virus is not destroyed by man's immune system.

Summary

AIDS no longer is the concern of any one segment of society; it is the concern of us all. No American's life is in danger if he/she or their sexual partners do not engage in high risk sexual behavior or use shared needles or syringes to inject illicit drugs into the body.

People who engage in high risk sexual behavior or who shoot drugs are risking infection with the AIDS virus and are risking their lives and the lives of others, including their unborn children.

We cannot yet know the full impact of AIDS on our society. From a clinical point of view, there may be new manifestations of AIDS — for example, mental disturbances due to the infection of the brain by the AIDS virus in carriers of the virus. From a social point of view, it may bring to an end the free-wheeling sexual lifestyle which has been called the sexual revolution. Economically, the care of AIDS patients will put a tremendous strain on our already overburdened and costly health care delivery system.

The most certain way to avoid getting the AIDS virus and to control the AIDS epidemic in the United States is for individuals to avoid promiscuous sexual practices, to maintain mutually faithful monogamous sexual relationships and to avoid injecting illicit drugs.

Look to the Future

The Challenge of the Future

An enormous challenge to public health lies ahead of us and we would do well to take a look at the future. We must be prepared to manage those things we can predict, as well as those we cannot.

At the present time there is no vaccine to prevent AIDS. There is no cure. AIDS, which can be transmitted sexually and by sharing needles and syringes among illicit intravenous drug users, is bound to produce profound changes in our society, changes that will affect us all.

Information and Education
Only Weapons Against AIDS

It is estimated that in 1991 54,000 people will die from AIDS. At this moment, many of them are not infected with the AIDS virus. With proper information and education, as many as 12,000 to 14,000 people could be saved in 1991 from death by AIDS.

AIDS will Impact All

The changes in our society will be economic and political and will affect our social institutions, our educational practices, and our health care. Although AIDS may never touch you personally,the societal impact certainly will.

Be Educated – Be Prepared

Be prepared. Learn as much about AIDS as you can. Learn to separate scientific information from rumor and myth. The Public Health Service, your local public health officials and your family physician will be able to help you.

Concern About Spread of AIDS

While the concentration of AIDS cases is in the larger urban areas today, it has been found in every state and with the mobility of our society, it is likely that cases of AIDS will appear far and wide.

Special Educational Concerns

There are a number of people, primarily adolescents, that do not yet know they will be homosexual or become drug abusers and will not heed this message; there are others who are illiterate and cannot heed this message. They must be reached and taught the risk behaviors that expose them to infection with the AIDS virus.

High Risk Get Blood Test

The greatest public health problem lies in the large number of individuals with a history of high risk behavior who have been infected with and may be spreading the AIDS virus. Those with high risk behavior must be encouraged to protect others by adopting safe sexual practices and by the use of clean equipment for intravenous drug use. If a blood test for antibodies to the AIDS virus is necessary to get these individuals to use safe sexual practices, they should get a blood test. Call your local health department for information on where to get the test.

Anger and Guilt

Some people afflicted with AIDS will feel a sense of anger and others a sense of guilt. In spite of these understandable reactions, everyone must join the effort to control the epidemic, to provide for the care of those with AIDS, and to do all we can to inform and educate others about AIDS, and how to prevent it.

Confidentiality

Because of the stigma that has been associated with AIDS, many afflicted with the disease or who are infected with the AIDS virus are reluctant to be identified with AIDS. Because there is no vaccine to prevent AIDS and no cure, many feel there is nothing to be gained by revealing sexual contacts that might also be infected with the AIDS virus. When a community or a state requires reporting of those infected with the AIDS virus to public health authorities in order to trace sexual and intravenous drug contacts – as is the practice with other sexually transmitted diseases – those infected with the AIDS virus go underground out of the mainstream of health care and education. For this reason current public health practice is to protect the privacy of the individual infected with the AIDS virus and to maintain the strictest confidentiality concerning his/her health records.

State and Local AIDS Task Forces

Many state and local jurisdictions where AIDS has been seen in the greatest numbers have AIDS task forces with heavy representation from the field of public health joined by others who can speak broadly to issues of access to care, provision of care and the availability of community and psychiatric support services. Such a task force is needed in every community with the power to develop plans and policies, to speak, and to act for the good of the public health at every level.

State and local task forces should plan ahead and work collaboratively with other jurisdictions to reduce transmission of AIDS by far-reaching informational and educational programs. As AIDS impacts more strongly on society, they should be charged with making recommendations to provide for the needs of those afflicted with AIDS. They also will be in the best position to answer the concerns and direct the activities of those who are not infected with the AIDS virus.

The responsibility of State and local task forces should be far reaching and might include the following areas:

- Insure enforcement of public health regulation of such practices as ear piercing and tattooing to prevent transmission of the AIDS virus.
- Conduct AIDS education programs for police, firemen, correctional institution workers and emergency medical personnel for dealing with AIDS victims and the public.
- Insure that institutions catering to children or adults who soil themselves or their surroundings with urine, stool, and vomitus have adequate equipment for cleanup and disposal, and have policies to insure the practice of good hygiene.

School

Schools will have special problems in the future. In addition to the guidelines already mentioned in this pamphlet, there are other things that should be considered such as sex education and education of the handicapped.

Sex Education

Education concerning AIDS must start at the lowest grade possible as part of any health and hygiene program. The appearance of AIDS could bring together diverse groups of parents and educators with opposing views on inclusion of sex education in the curricula. There is now no doubt that we need sex education in schools and that it must include information on heterosexual and homosexual relationships. The threat of AIDS should be sufficient to permit a sex education curriculum with a heavy emphasis on prevention of AIDS and other sexually transmitted diseases.

Handicapped and Special Education

Children with AIDS or ARC will be attending school along with others who carry the AIDS virus. Some children will develop brain disease which will produce changes in mental behavior. Because of the right to special education of the handicapped and the mentally retarded, school boards and higher authorities will have to provide guidelines for the management of such children on a case-by-case basis.

Labor and Management

Labor and management can do much to prepare for AIDS so that misinformation is kept to a minimum. Unions should issue preventive health messages because many employees will listen more carefully to a union message than they will to one from public health authorities.

AIDS Education at the Work Site

Offices, factories, and other work sites should have a plan in operation for education of the work force and accommodation of AIDS or ARC patients *before* the first such case appears at the work site. Employees with AIDS or ARC should be dealt with as are any workers with a chronic illness. In-house video programs provide an excellent source of education and can be individualized to the needs of a specific work group.

Strain on the Health Care Delivery System

The health care system in many places will be overburdened as it is now in urban areas with large numbers of AIDS patients. It is predicted that during 1991 there will be 145,000 patients requiring hospitalization at least once and 54,000 patients who will die of AIDS. Mental disease (dementia) will occur in some patients who have the AIDS virus before they have any other manifestation such as ARC or classic AIDS.

State and local task forces will have to plan for these patients by utilizing conventional and time honored systems but will also have to investigate alternate methods of treatment and alternate sites for care including homecare.

The strain on the health system can be lessened by family, social, and psychological support mechanisms in the community. Programs are needed to train chaplains, clergy, social workers, and volunteers to deal with AIDS. Such support is particularly critical to the minority communities.

Mental Health

Our society will also face an additional burden as we better understand the mental health implications of infection by the AIDS virus. Upon being informed of infection with the AIDS virus, a young, active, vigorous person faces anxiety and depression brought on by fears associated with social isolation, illness, and dying. Dealing with these individual and family concerns will require the best efforts of mental health professionals.

Controversial Issues

A number of controversial AIDS issues have arisen and will continue to be debated largely because of lack of knowledge about AIDS, how it is spread, and how it can be prevented. Among these are the issues of compulsory blood testing, quarantine, and identification of AIDS carriers by some visible sign.

Compulsory Blood Testing

Compulsory blood testing of individuals is not necessary. The procedure could be unmanageable and cost prohibitive. It can be expected that many who *test* negatively might actually be positive due to *recent* exposure to the AIDS virus and give a false sense of security to the individual and his/her sexual partners concerning necessary protective behavior. The prevention behavior described in this report, if adopted, will protect the American public and contain the AIDS epidemic. Voluntary testing will be available to those who have been involved in high risk behavior.

Quarantine

Quarantine has no role in the management of AIDS because AIDS is not spread by casual contact. The only time that some form of quarantine might be indicated is in a situation where an individual carrying the AIDS virus knowingly and willingly continues to expose others through sexual contact or sharing drug equipment. Such circumstances should be managed on a case-by-case basis by local authorities.

Identification of AIDS Carriers by Some Visible Sign

Those who suggest the marking of carriers of the AIDS virus by some visible sign have not thought the matter through thoroughly. It would require testing of the entire population which is unnecessary, unmanageable and costly. It would miss those recently infected individuals who would test negatively, but be infected. The entire procedure would give a false sense of security. AIDS must and will be treated as a disease that can infect anyone. AIDS should not be used as an excuse to discriminate against any group or individual.

Updating Information

As the Surgeon General, I will continually monitor the most current and accurate health, medical, and scientific information and make it available to you, the American people. Armed with this information you can join in the discussion and resolution of AIDS-related issues that are critical to your health, your children's health, and the health of the nation.

Additional Information

Telephone Hotlines (Toll Free)

PHS AIDS Hotline
800-342-AIDS
800-342-2437

National Sexually Transmitted Diseases Hotline/
American Social Health Association
800-227-8922

National Gay Task Force
AIDS Information Hotline
800-221-7044
(212) 807-6016 (NY State)

Information Sources

U.S. Public Health Service
Public Affairs Office
Hubert H. Humphrey
Building, Room 725-H
200 Independence Avenue, S.W.
Washington, D.C. 20201
Phone: (202) 245-6867

Local Red Cross or
American Red Cross
AIDS Education Office
1730 D Street, N.W.
Washington, D.C. 20006
Phone: (202) 737-8300

American Association of Physicians for Human Rights
P.O. Box 14366
San Francisco, CA 94114
Phone: (415) 558-9353

AIDS Action Council
729 Eighth Street, S.E.,
Suite 200
Washington, D.C. 20003
Phone: (202) 547-3101

Gay Men's Health Crisis
P.O. Box 274
132 West 24th Street
New York, NY 10011
Phone: (212) 807-6655

Hispanic AIDS Forum
c/o APRED
853 Broadway, Suite 2007
New York, NY 10003
Phone: (212) 870-1902 or
870-1864

Los Angeles AIDS Project
7362 Santa Monica
Boulevard
Los Angeles, California
90046
(213) 876-AIDS

Minority Task Force on AIDS
c/o New York City Council
of Churches
475 Riverside Drive,
Room 456
New York, NY 10115
Phone: (212) 749-1214

Mothers of AIDS Patients (MAP)
c/o Barbara Peabody
3403 E Street
San Diego, CA 92102
(619) 234-3432

National AIDS Network
729 Eighth Street, S.E.,
Suite 300
Washington D.C. 20003
(202) 546-2424

National Association of People with AIDS
P.O. Box 65472
Washington, D.C. 20035
(202) 483-7979

National Coalition of Gay Sexually Transmitted Disease Services
c/o Mark Behar
P.O. Box 239
Milwaukee, WI 53201
Phone: (414) 277-7671

National Council of Churches/AIDS Task Force
475 Riverside Drive,
Room 572
New York, NY 10115
Phone: (212) 870-2421

San Francisco AIDS Foundation
333 Valencia Street,
4th Floor
San Francisco, CA 94103
Phone: (415) 863-2437

U.S. PUBLIC HEA
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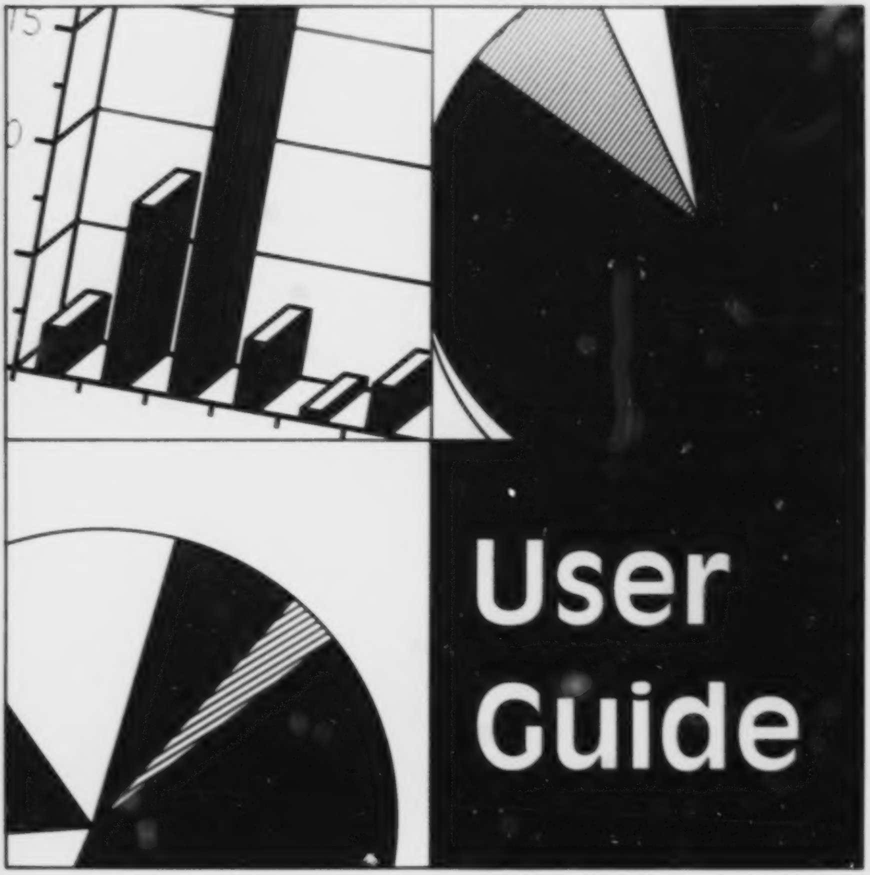
NAIC

National AIDS Information Clearinghouse



User Guide

U.S. Department of Health and Human Services
Public Health Service
Centers for Disease Control

NAIC

National AIDS Information Clearinghouse

User Guide

March 1989

U.S. Department of Health and Human Services
Public Health Service
Centers for Disease Control

AIDS Information

This Guide will familiarize you with the wealth of information available through NAIC. It describes NAIC's services and resources and how to obtain them.

NAIC users can obtain reference assistance and referrals to organizations providing AIDS-related services by calling **1–301–762–5111** between 9:00 a.m. and 7:00 p.m., eastern time, Monday through Friday.

For multiple copies of selected AIDS publications produced by the U.S. Public Health Service, other Federal agencies, and national organizations call the National AIDS Information Clearinghouse at **1–800–458–5231** between 9:00 a.m. and 7:00 p.m., eastern time, Monday through Friday.

The public can obtain single copies of AIDS-related publications and other materials by calling the National AIDS Hotline at 1–800–342–AIDS (English), 1–800–344–SIDA (Spanish); or 1–800–AIDS–TTY (TDD/TTY for deaf and hard of hearing people). The toll-free Hotline provides 24-hour service to answer questions about AIDS and to offer referrals to appropriate services.

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The National AIDS
Information Clearinghouse

About NAIC

The National AIDS Information Clearinghouse (NAIC) was initiated in October 1987 by the U.S. Public Health Service, Centers for Disease Control (CDC), as part of its national information and education plan in response to the grave threat to the public health posed by acquired immunodeficiency syndrome (AIDS).

NAIC is a *centralized resource* providing accurate and current information on AIDS programs, materials, and services. NAIC's purposes are to:

☐ Identify and respond to the information needs of health professionals involved in the development and delivery of State HIV-prevention programs.

☐ Ensure that the general public has access to available information on HIV infection and AIDS.

☐ Provide technical assistance and an information and communications network among organizations involved in the fight against AIDS, particularly State health departments.

☐ Assist in the development and assessment of resources.

☐ Support all AIDS information delivery services of CDC, including the National AIDS Hotline.

☐ Distribute selected publications.

The Public Health Service's AIDS information strategy recognizes that the most effective means of controlling the AIDS epidemic is education—factual, consistent, and understandable information about HIV infection and AIDS. Moreover, different groups need different kinds of information. The Clearinghouse, together with CDC's National AIDS Hotline, enables CDC to meet the specific information needs of a broad range of groups and individuals.

NAIC Services and Resources

Reference and Referral Services

Staff specialists with a broad knowledge of AIDS issues are available to answer questions, make referrals, and suggest publications pertaining to HIV infection and AIDS. Requests for information from NAIC can be made either by writing NAIC, P.O. Box 6003, Rockville, MD 20850, or by calling 1–301–762–5111 from 9:00 a.m. until 7:00 p.m., eastern time, Monday through Friday. During these hours, reference specialists, some of whom speak Spanish as well as English, are available to help you obtain the information you need. Responses to inquiries will be sent within 5 working days and can be tailored to special requirements.

For example, you can receive information about:

☐ HIV prevention.

☐ Community-based patient support groups.

☐ Policies and procedures for handling AIDS-related issues in school, the workplace, and in health care organizations.

☐ Organizations responsible for training counselors, educators, and other outreach personnel.

Your call to the Clearinghouse puts you in touch with reference specialists who have this information and much more, organized and computerized for instant accessibility. And, reference specialists with expertise in areas such as minority issues related to AIDS can help local and State HIV-prevention program staff identify appropriate programs.

State-of-the-Art Databases

All of NAIC's information is stored in a database format, which is a collection of information entered into a computer in a standard way so that it can be retrieved easily. Two databases form the core of information for the Clearinghouse:

☐ Resources Database, an inventory of organizations providing HIV- and AIDS-related services and resources.

☐ Educational Materials Database, a collection of HIV-and AIDS-related educational materials produced throughout the Nation.

These databases are the largest and most comprehensive of their kind anywhere. They contain information and materials that have been gathered from a variety of sources, including:

☐ Organizations prominent in the field, such as large community-based organizations.

☐ State HIV Prevention Program Coordinators.

☐ AIDS hotlines and telephone counseling services.

☐ Newsletters, journals, directories, and other secondary sources.

The Resources Database

The Resources Database is composed of thousands of programs, projects, and organizations providing HIV- and AIDS-related services. Information on the services provided, target audiences or clientele, geographic area served, contact persons, hours, and more is included.

The Resources Database is updated daily with new information and materials received from organizations and through feedback from users.

Many callers are interested in finding programs that provide a specific service. The Resources Database is particularly useful because all the services provided by each organization are listed, along with hard-to-find information such as who to call for a particular service, or what special populations are served.

An organization's database record includes the name, address, telephone number, a brief description of services offered, clientele, and more. If the organization provides an outreach program for minorities, the record has a code indicating this. By entering this code into the computer, an NAIC reference specialist can instantly find all the organizations that offer that service. These services can be very specific; for example, reference specialists can locate all the programs that provide outreach to minorities in Chicago.

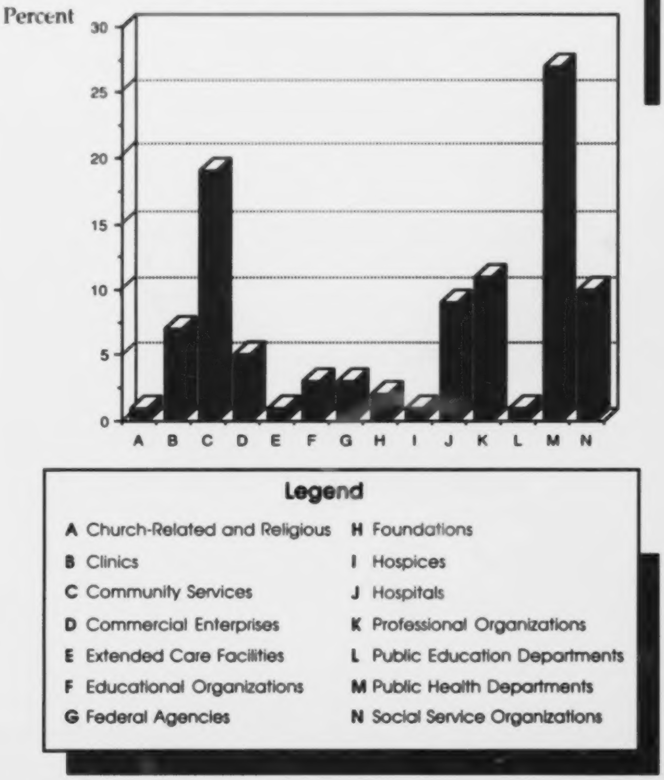
The Resources Database also includes foundations that provide funding for research activities such as the American Foundation for AIDS Research; professional organizations like the American Medical Association; and community service organizations.

Once information is collected and it is determined that an organization meets NAIC criteria, a standard-format description is prepared. Following a rigorous process of internal validation of the description's accuracy, it is entered into NAIC's computer system. The entire process is done according to strict guidelines that reflect the best in current information science practice.

Figure 1 shows a breakdown of the types of organizations in the Resources Database.

Figure 1

Organization Types in the Resources Database*



* As of December 1988

Figures 2 and 3 show the distribution of services offered by organizations listed in the Resources Database.

Figure 2

Information, Education, Research*

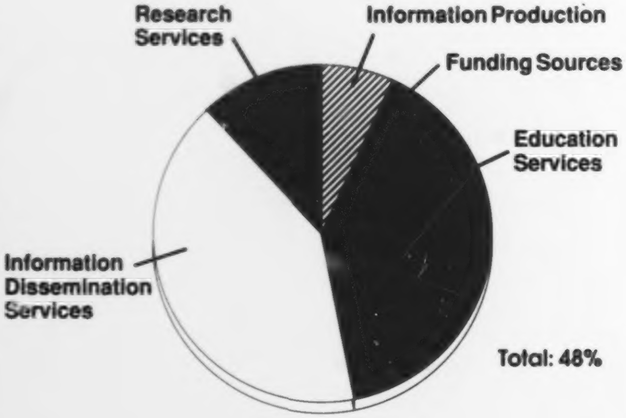
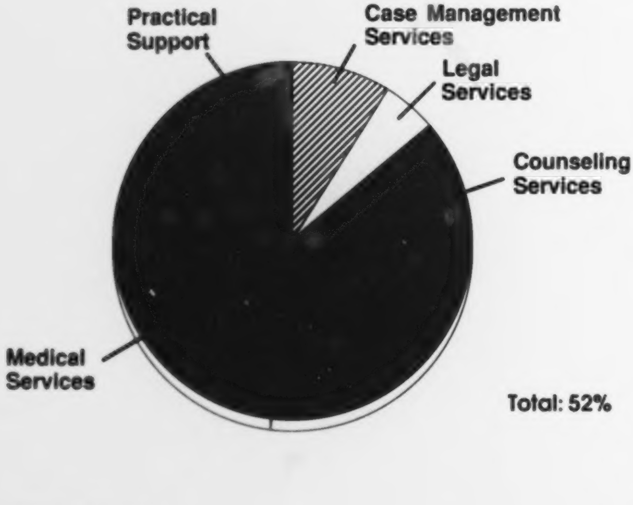


Figure 3

Human Services*



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* As of December 1988

In addition to in-house quality control, the organization descriptions are further validated through verification by the originating organization. NAIC also submits the descriptions for review by national organizations and State HIV Prevention Program Coordinators.

Public access to a portion of the Resources Database is available through the National Library of Medicine's Directory of Information Resources Online (DIRLINE).

The Educational Materials Database

The Educational Materials Database contains information about educational materials tailored to specific audiences and focusing on different aspects of HIV infection and AIDS. If you are organizing or managing an information program for a specific group, NAIC's Educational Materials Database can help you locate materials appropriate to your audience.

The Educational Materials Database contains a comprehensive collection of materials in a variety of formats, from study guides to comic books. It includes audiovisual materials as well—audiocassettes, videotapes, and displays.

NAIC's policy is to include an assortment of helpful educational materials recognizing the diversity and variety of needs among the different populations affected by AIDS.

The Educational Materials Database includes the following types of documents, which can be obtained from the sources listed in the database records:

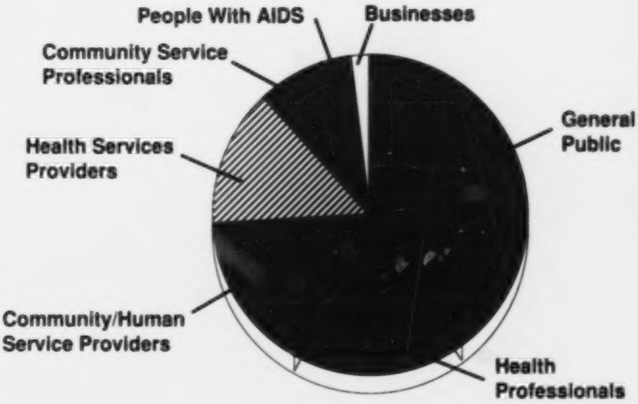
☐ Pamphlets
☐ Brochures
☐ Teaching Guides
☐ Handbooks
☐ Training Manuals
☐ Policy and Procedure Manuals
☐ Directories
☐ Reports or Monographs
☐ Bibliographies
☐ Computer Software
☐ Audiovisuals

The materials are abstracted and indexed according to stringent guidelines. Following a thorough quality control review, the descriptions are entered into the database.

The database contains information about educational materials suitable for use with the audiences listed in Figure 4.

Figure 4

The Educational Materials Database*



The Educational Materials Database is available as a subfile on the BRS Combined Health Information Database (CHID).

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* As of December 1988

NAIC: The Central Resource for AIDS Materials

NAIC is the distribution point for selected AIDS publications available from the U.S. Public Health Service, other Federal agencies, and national organizations. NAIC distributes bulk orders to its user community, as well as millions of single copies to individuals requesting them through the National AIDS Hotline. NAIC distributes copies of more than 60 brochures, pamphlets, fact sheets, posters, and booklets. The Appendix provides a brief description of each item and ordering instructions.

Outreach Services

The Clearinghouse has taken a proactive role in its efforts to provide resources and information to those charged with the task of educating the public about AIDS and HIV infection. A key component of NAIC's operation is its Outreach Services. NAIC personnel are available to provide technical assistance in AIDS program development and management to government agencies, and organizations and professionals in a variety of health and public service fields.

As part of its outreach efforts, the Clearinghouse:

☐ Provides conference support, including exhibiting and disseminating materials about Clearinghouse resources at conferences and meetings that have sessions devoted to HIV infection and AIDS.

☐ Develops collaborative programs with organizations responsible for the delivery of HIV- and AIDS-related services.

☐ Helps agencies mobilize groups and individuals in health education efforts.

☐ Distributes a monthly conference calendar of HIV- and AIDS-related conferences.

For assistance or more information about NAIC's Outreach Services, call 1–301–762–5111.

Future Services

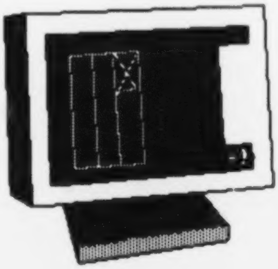
NAIC evaluates its services and resources on an ongoing basis. Future services being developed in response to user needs include:

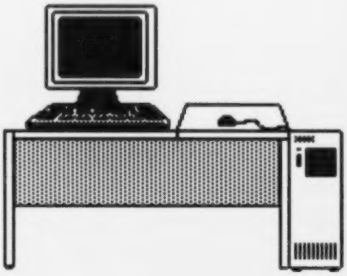
☐ Public resource center

☐ Electronic bulletin board

☐ State and organizational directories

☐ Technical assistance to State public health programs





Get **answers.**
Get **facts.**

Call the **National AIDS Information Clearinghouse** today—
1–301–762–5111,
or write
NAIC,
P.O. Box 6003,
Rockville, MD 20850.

Appendix

How To Order

For free single copies of the materials listed in this section, call the toll-free National AIDS Hotline: 1–800–342–AIDS, 1–800–344–SIDA (Spanish-speaking callers), or 1–800–AIDS–TTY (for deaf and hard of hearing people).

For multiple copies, call NAIC at 1–800–458–5231 between 9:00 a.m. and 7:00 p.m., Monday through Friday, eastern time. Bilingual operators are available to take orders from Spanish-speaking callers. The number of copies per request may be limited according to availability. There are no copyright restrictions on Public Health Service materials so you may copy or reprint as many as you need.

Three publications are available in camera-ready negative form for reprinting:

- ☐ *The Surgeon General's Report* (English or Spanish).
- ☐ *Facts About AIDS* (English or Spanish).
- ☐ *What You Should Know About AIDS.*

For ordering information on these camera-ready negatives call NAIC at 1–800–458–5231.

311

Surgeon General's Report on Acquired Immune Deficiency Syndrome
NAIC order number: 001
U.S. Public Health Service, 1986

A 35-page booklet that summarizes current knowledge about AIDS, and tells how AIDS is transmitted, the risk of infection, and how to prevent infection. Suitable for a general audience. Explains in plain language how the AIDS virus attacks the body, the signs and symptoms of AIDS, estimates of how many people are infected, and how the disease is and is not spread. Addresses misconceptions about AIDS. Emphasizes the importance of education for AIDS prevention beginning with school-age children, and concludes with a look at controversial issues surrounding AIDS. Lists additional information sources. Illustrated. *Available in camera-ready negative form for reprinting.*

Informe del Jefe del Servicio de Salud Pública de los Estados Unidos Sobre el Síndrome de Inmuno-Deficiencia Adquirida (AIDS)
NAIC order number: 002
U.S. Public Health Service, 1986

Surgeon General's Report on Acquired Immune Deficiency Syndrome in Spanish (for description, see order number 001 above). *Available in camera-ready negative form for reprinting.*

What You Should Know About AIDS
NAIC order number: 003
U.S. Public Health Service, 1988

An eight-panel brochure for the general public that provides facts about the signs and symptoms of AIDS. Responds to concerns about catching the disease through casual contact. Explains how people contract and transmit AIDS and gives some general tips on avoiding infection. Family oriented. *Available in camera-ready negative form for reprinting.*

AIDS and Children: Information for Parents of School-Age Children
NAIC order number: 004
American Red Cross, 1986

A five-page booklet that answers commonly asked questions about how AIDS is spread. Reassures parents that casual contact does not result in infection. Explains who is at risk and why, and briefly outlines ways to protect oneself and one's family from the disease.

AIDS and Children: Information for Teachers and School Officials
NAIC order number: 005
American Red Cross, 1986

A seven-page booklet that answers commonly asked questions about how AIDS is spread. Explains that casual contact, such as might occur between schoolchildren, does not result in infection. Describes in clinical terms how AIDS is spread; lists groups at risk of contracting

AIDS and of passing AIDS on to their children. Includes guidelines developed by the U.S. Public Health Service to assist State and local health and education departments in planning for the education and foster care of children with AIDS. Suggests sources of additional information.

AIDS and the Safety of the Nation's Blood Supply
NAIC order number: 006
American Red Cross, 1987

A five-page booklet that focuses on implications of AIDS for America's blood supply. Issues addressed include the safety of blood transfusions, measures taken to protect the blood supply, and the reliability of the test for the HIV antibody. Includes a list of high-risk groups that should not donate blood.

Caring for the AIDS Patient at Home
NAIC order number: 009
American Red Cross, 1986

A six-page booklet that describes what caring for AIDS patients at home involves. Reassures caregivers that with proper precautions they need not fear infection. Discusses ways to make patients comfortable and protect them from opportunistic infections. Lists guidelines for home care providers for avoiding infection with the AIDS virus.

If Your Test for Antibody to the AIDS Virus Is Positive
NAIC order number: 012
American Red Cross, 1986

A five-page booklet that discusses the AIDS antibody test, the meaning of a positive test result, and ways to protect one's own health and that of others in the event of a positive test result. Advice for those who test positive: avoid transmitting body fluids to others; continue normal activities; and work closely with a physician who will provide followup care.

Facts About AIDS
NAIC order number: 013
U.S. Public Health Service, 1987

A nine-page booklet that provides, in question-and-answer format, accurate information about AIDS: what it is, what causes it, how it is transmitted, who is at risk, and what the clinical features of the disease are. Includes recommendations for the general public, for those at increased risk of infection, and for those who test positive for antibodies to the AIDS virus. *Available in camera-ready negative form for reprinting.*

Coping With AIDS: Psychological and Social Considerations in Helping People With HTLV–III Infection

NAIC order number: 014
National Institute of Mental Health, 1986

A 20-page booklet for health care providers that describes the emotional and psychological problems faced by AIDS patients. Provides background information on AIDS, including clinical manifestations, neuropsychiatric considerations, and preventive measures. Recommends ways to help AIDS patients cope with their disease. Recommended readings and various AIDS hotline telephone numbers are included.

Protection Against Occupational Exposure to Hepatitis B Virus (HBV) and Human Immunodeficiency Virus (HIV)

NAIC order number: 016
U.S. Department of Labor and U.S Department of Health and Human Services, 1987

A 14-page Joint Advisory Notice on risks of occupational infection by the human immunodeficiency virus (HIV) and by hepatitis B virus (HBV). Presents findings from several studies of health care workers; one showed that only one of 396 workers exposed to AIDS-infected blood tested positive for antibodies to HIV. Reviews how the two viruses are transmitted. Recommends ways for health care workers to reduce the risk of infection. Methods include administrative controls, training and education, engineering controls, work practice controls, and personal protective equipment. Extensive bibliography.

Datos sobre el SIDA
NAIC order number: 017
U.S. Public Health Service, 1987

Spanish-language version of *Facts About AIDS* (for description, see order number 013). *Available in camera-ready negative form for reprinting.*

Guidelines for Effective School Health Education to Prevent the Spread of AIDS
NAIC order number: 018
Morbidity and Mortality Weekly Report 37(S–2): January 29, 1988
U.S. Public Health Service, 1988

A 14-page report that contains guidelines for school personnel to help them develop effective AIDS educational programs. Suggests objectives and content of AIDS education for different age levels. Includes nine criteria for assessing effectiveness of AIDS education programs in the schools. President Reagan's Domestic Policy Council's principles for AIDS education are appended, as well as a report on the extent of AIDS and indicators of adolescent risk. References are included. *Restricted to educators.*

Human Immunodeficiency Virus Infection in the United States: A Review of Current Knowledge
NAIC order number: 021
Morbidity and Mortality Weekly Report 36(S–6):
December 18, 1987
U.S. Public Health Service, 1987

Summary of published and unpublished information on the epidemiology of human immunodeficiency virus (HIV) infection in the United States. Data on incidence drawn from a variety of government agencies and medical institutions. Provides incidence figures for high-risk groups and selected segments of the general population, such as blood donors, civilian applicants for military services, and hospital patients. Covers geographic and demographic aspects of HIV-infection prevalence, as well as trends and implications. Includes tables, figures, and references.

AIDS Education: A Business Guide Packet
NAIC order number: 027
American Foundation for AIDS Research,
American Council of Life Insurance, Health
Insurance Association of America, September
1987

This packet includes a Clearinghouse brochure and publications list, a Public Health Service brochure (order no. 016), two *Morbidity and Mortality Weekly Report* publications (order nos. 021, 031), and a 44-page guide that describes principles and programs for AIDS education in the workplace. Included in the guide's appendixes are frequently asked questions and answers.

Recommendations for Prevention of HIV Transmission in Health-Care Settings
NAIC order number: 030
Morbidity and Mortality Weekly Report 36(25):
August 21, 1987
U.S. Public Health Service, 1987

Updated guidelines for preventing human immunodeficiency virus (HIV) transmission in health care settings. Includes precautions for clinical and laboratory staffs, precautions for health care workers and allied professionals, recommendations for preventing HIV transmission in the workplace and during invasive procedures, recommendations for preventing transmission of the virus from tears, and guidelines for dialysis treatment of HIV-infected patients. Updates guidelines for isolation procedures in hospitals, and makes recommendations for infection control in the practice of dentistry. Emphasizes the need to treat blood and other body fluids from all patients as potentially infectious. References are included. *Restricted to health care professionals.*

Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Blood-Borne Pathogens in Health-Care Settings
NAIC order number: 031
Morbidity and Mortality Weekly Report, 37(24):
June 24, 1988
U.S. Public Health Service, 1988

A five-page update of guidelines for prevention of transmission of blood-borne pathogens in health care environments. Clarifies the following issues: body fluids to which universal precautions apply; use of protective barriers; use of gloves for phlebotomy; selection of gloves for use while observing universal precautions; and need for making changes in waste management programs as a result of adopting universal precautions. Includes references. *Restricted to health care professionals.*

Understanding AIDS*
NAIC order number: 033
U.S. Public Health Service, 1988

An eight-page brochure, distributed in a national mailing, explains in question-and-answer format basic facts about AIDS; how AIDS is and is not transmitted; and how to avoid infection. Identifies risky behaviors. Targeted to the general public. Includes a quiz on the material presented.

Entendiendo el SIDA
NAIC order number: 034
U.S. Public Health Service, 1988

A Spanish-language version of *Understanding AIDS* (for description, see order number 033).

Understanding AIDS
NAIC order number: 040
U.S. Public Health Service, 1988

An oversize, braille version of *Understanding AIDS*, for the visually impaired (for description, see order number 033).

* In addition to the translations listed here, *Understanding AIDS* will be available in the following languages: Cambodian, Vietnamese, Laotian, and Haitian/Creole.

Compreender a SIDA
NAIC order number: 111
U.S. Public Health Service, 1988

Understanding AIDS in Portuguese (for description, see order number 033).

Understanding AIDS
NAIC order number: 112
U.S. Public Health Service, 1988

Understanding AIDS in Chinese (for description, see order number 033).

AIDS Information Monitor
A Summary of National Public Opinion Surveys On AIDS: 1983 Through 1986
NAIC order number: 046
American Red Cross, 1988

A 275-page summary of all available national public opinion polls on AIDS conducted between 1983 and 1986. The intent is to document trends in public opinion related to AIDS, to identify areas of fear and misinformation that could serve as potential targets for public education, and identify potential intervention strategies for motivating the general public and population subgroups toward risk-reduction behavior.

What About AIDS Testing?
NAIC order number: 048
U.S. Public Health Service, 1988

A five-page booklet that reviews the ways AIDS can be spread. It discusses the antibody test ELISA (also called EIA) and the two tests (Western Blot and IFA) given if the ELISA test is positive. The booklet lists behaviors that put one at risk for AIDS, describes the AIDS test, and discusses "confidential" and "anonymous" testing practices. Counseling is strongly suggested for anyone being tested. The reader is referred to the National AIDS Hotline, SIDA (Spanish) Hotline, and the Hearing Impaired (TTY) Hotline for more information on AIDS and testing. Prepared in conjunction with the America Responds to AIDS Campaign, 1988.

How You Won't Get AIDS
NAIC order number: 049
U.S. Public Health Service, 1988

A three-page pamphlet with general information that explains how you can and cannot get AIDS. It discusses the difference between getting and giving blood. The reader is referred to the National AIDS Hotline, SIDA (Spanish) Hotline, and Hearing Impaired (TTY) Hotline for more information on AIDS. Prepared in conjunction with the America Responds to AIDS Campaign, 1988.

1988 Agent Summary Statement for Human Immunodeficiency Virus and Report on Laboratory-Acquired Infection With Human Immunodeficiency Virus
NAIC order number: 069
Morbidity and Mortality Weekly Report, 37 (S–4): April 1, 1988
U.S. Public Health Service

A 22-page report that provides safety guidelines for operating microbiologic and biomedical laboratories. The guidelines are based on combinations of standard and special practices, equipment, and facilities recommended for use in working with infectious agents in various laboratory settings. Includes a section containing specific agent summary statements, each consisting of a brief description of laboratory-associated infections, the nature of laboratory hazards, and recommended precautions for working with a causative agent. Also provides an updated description of human immunodeficiency virus (HIV).

AIDS and Deafness, Resource Directory
NAIC order number: 070
Gallaudet University and National AIDS Information Clearinghouse, 1989

A 77-page directory that provides access to organizations that offer AIDS-related services to deaf and hearing impaired people. This directory is an outgrowth of the first National Conference on AIDS and Deafness sponsored by Gallaudet University in June 1988.

Report of the Second Public Health Service AIDS Prevention and Control Conference
NAIC order number: 071
U.S. Public Health Service, 1988

A summary of the Second Public Health Service AIDS Prevention and Control Conference that examined the current dimensions of the HIV problem and assessed the agency's progress. Presents a comprehensive and realistic strategy for further progress in the Nation's response to AIDS. Identifies specific issues, goals, and objectives as priority areas for Public Health Service efforts in controlling the HIV epidemic. Covers the nine major areas of activity on AIDS and HIV infection within the Public Health Service and includes sections on the HIV epidemic as it affects women, minorities, and children.

AIDS HIV Monthly Surveillance Report
NAIC order number: 113
U.S. Public Health Service, 1989

A monthly report of AIDS statistics reported to CDC for all 50 States, the District of Columbia, and U.S. dependencies and possessions. CDC uses the orginal definition of AIDS as modified in 1985 (MMWR 1985; 34) and again in 1987 (MMWR 1987; 36: Suppl. no. 1S). Report statistics are broken down by State, metropolitan areas, age, and other categories. Issues are available from February 1989.

Each point of purchase display includes five pads of 50 fact sheets and one cardboard easel-backed display.

Understanding AIDS
NAIC order number: 051
U.S. Public Health Service, 1988

This fact sheet, featuring a statement by Surgeon General C. Everett Koop, describes behavior that puts one at risk for AIDS. It discusses AIDS and drugs, AIDS and babies, the use of condoms, and talking to children about AIDS. The test for AIDS is discussed as well as recommendations of who should consider being tested.

Hispanics Get AIDS, Too
NAIC order number: 052
U.S. Public Health Service, 1988

A fact sheet, featuring a Latino family, describes ways in which AIDS is transmitted and spread, and how to protect oneself and one's family.

Los Hispanos también adquieren el SIDA
NAIC order number: 053
U.S. Public Health Service, 1988

A Spanish version of *Hispanics Get AIDS, Too* (for description see order number 052).

Three Words Every Black Person Should Know: AIDS Doesn't Discriminate
NAIC order number: 054
U.S. Public Health Service, 1988

A fact sheet that describes how AIDS is transmitted and spread, the relationship between drugs and AIDS, and AIDS and babies. It also discusses what children need to know about AIDS and how to discuss safe sex with your partner.

Posters

¿Cómo se adquiere el SIDA?
NAIC order number: 043
U.S. Public Health Service, 1988

Glossy poster with factual information on how AIDS is spread. Illustrated with a picture of Jennie Reyes, mother and AIDS volunteer.

Ayudando una persona que tiene SIDA
NAIC order number: 044
U.S. Public Health Service, 1988

Glossy poster illustrated with a picture of Dr. Kenneth Castro from the AIDS program at the Centers for Disease Control. This poster points out that a person with AIDS doesn't necessarily look or feel ill but still can be carrying the virus.

El SIDA y los bebés
NAIC order number: 045
U.S. Public Health Service, 1988

Glossy poster illustrated with a picture of an infant, discusses the ways in which AIDS is spread from a woman to her unborn child.

The following posters were prepared in conjunction with the America Responds to AIDS Campaign, 1988. These posters refer the reader to the National AIDS Hotline for information about AIDS.

How You Won't Get AIDS
NAIC order number: 055
U.S. Public Health Service

This set of four color posters explains that people can't get AIDS through casual contact. Intended for use by education and health departments for distribution to schools.

AIDS Is Scary, But a Zit Is Real, Right?
NAIC order number: 058
U.S. Public Health Service, 1988

This poster stresses AIDS awareness, and features a young male teen.

What Do You Do When Your Best Friend Has AIDS?
NAIC order number: 059
U.S. Public Health Service, 1988

This poster, in dialog format, explores the emotions experienced when a loved one has AIDS. Features a young black female.

"I Didn't Know I Had AIDS . . . Not Until My Baby Was Born With It"
NAIC order number: 060
U.S. Public Health Service, 1988

A young black female discusses how she got AIDS from her boyfriend, who was shooting drugs, and passed the disease on to her baby.

If You're Dabbling in Drugs . . . You Could Be Dabbling With Your Life
NAIC order number: 061
U.S. Public Health Service, 1988

This poster, featuring a young black male, discusses drug abuse and how it can lead to AIDS.

He Wouldn't Give Up Shooting Up . . . So I Gave Him Up
NAIC order number: 062
U.S. Public Health Service, 1988

A young Hispanic female is featured in this poster, which discusses how one woman left a relationship with a drug abuser to avoid getting AIDS.

El no dejó de inyectarse drogas . . . por eso lo dejé
NAIC order number: 063
U.S. Public Health Service, 1988

The Spanish-language version of *He Wouldn't Give Up Shooting Up . . . So I Gave Him Up* (for description, see order number 062).

What Have You Got Against A Condom?
Set A
NAIC order number: 064
U.S. Public Health Service, 1988

A set of six black and white posters encouraging the use of condoms to avoid getting AIDS. Included in this set is a poster titled"Stop Worrying About How You Won't Get AIDS. And Worry About How You Can." Intended for use by the general public. *Each of the six posters is available individually in packages of 10.*

What Have You Got Against A Condom?
Set B
NAIC order number: 065
U.S. Public Health Service, 1988

A set of 12 black and white posters encouraging the use of condoms to avoid getting AIDS. Included in this set is a poster titled"Stop Worrying About How You Won't Get AIDS. And Worry About How You Can." Intended for use by minority groups. *Each of the twelve posters is available individually in packages of 10. Includes three Spanish-language posters.*

The following posters are only available in sets of 10 (maximum order of 10 sets).

Do You Talk About AIDS on the First Date?
NAIC order number: 072
U.S. Public Health Service, 1988

This poster presents a brief dialog with a young male about AIDS and dating.

How Would You Deal With It If One of You Got AIDS?
NAIC order number: 074
U.S. Public Health Service, 1988

Two males and a female are pictured in this poster that discusses how to deal with a friend who has AIDS.

Have You Talked With Your Wife About AIDS?
NAIC order number: 075
U.S. Public Health Service, 1988

A man in work clothes emphasizes the need to talk frankly with loved ones about AIDS.

Your Daughter Worries About AIDS
NAIC order number: 076
U.S. Public Health Service, 1988

Using a father and daughter as an example, this poster stresses the parents' role in talking to children about AIDS.

Heard Much About AIDS Lately?
NAIC order number: 077
U.S. Public Health Service, 1988

A middle-aged woman emphasizes the importance of talking about AIDS.

How About Dinner, a Movie, and a Talk About AIDS?
NAIC order number: 079
U.S. Public Health Service, 1988

A young woman discusses dating and AIDS.

If Your Man Is Dabbling in Drugs . . . He Could Be Dabbling With Your Life
NAIC order number: 081
U.S. Public Health Service, 1988

This poster discusses the relationship between AIDS and drugs and what to do if your sexual partner is on drugs and at risk for AIDS. It features a young black woman.

On the Wrong Track
NAIC order number: 085
U.S. Public Health Service, 1988

This poster explains the relationship between AIDS and drugs and highlights how a woman can protect herself against AIDS if her sexual partner shoots drugs.

Huellas peligrosas
NAIC order number: 086
U.S. Public Health Service, 1988

A Spanish version of *On the Wrong Track* (for description, see order number 085).

A Message to the Third Man in My Life
NAIC order number: 087
U.S. Public Health Service, 1988

A single mother, pictured with her two sons, talks about taking precautions against AIDS.

Un mensaje al tercer hombre en mi vida
NAIC order number: 088
U.S. Public Health Service, 1988

A Spanish version of *A Message to the Third Man in My Life* (for description, see order number 087).

If You Cheat on Your Partner, You Could Wind Up With More Than Just a Broken Heart
NAIC order number: 089
U.S. Public Health Service, 1988

This poster, featuring a black couple, discusses AIDS and the importance of knowing your partner.

No Matter What Shape You're in, Anyone Can Get the AIDS Virus
NAIC order number: 090
U.S. Public Health Service, 1988

An athletic black male is pictured in this poster, which talks about people with active social lives and encourages sexual responsibility.

I Love Sex
NAIC order number: 091
U.S. Public Health Service, 1988

The poster's message is geared toward married couples and deals with sex, fidelity, and AIDS.

Me encanta hacer el amor
NAIC order number: 092
U.S. Public Health Service, 1988

A Spanish version of *I Love Sex* (for description, see order number 091).

Three Good Reasons For Not Being Out With the Boys
NAIC order number: 093
U.S. Public Health Service, 1988

An Hispanic man, pictured with his family, offers a male perspective of behavior that puts one at risk for AIDS.

Tres razones para no andar en la calle con los muchachos
NAIC order number: 094
U.S. Public Health Service, 1988

A Spanish version of *Three Good Reasons For Not Being Out With the Boys* (for description, see order number 093).

AIDS and the Education of Our Children

A Guide for Parents and Teachers

U.S. Department of Education

AIDS and the Education of Our Children

A Guide for Parents and Teachers

United States Department of Education
William J. Bennett, Secretary
January 1988
Third printing

On February 11, 1987, President Reagan established the following principles to guide Federal assistance regarding education about AIDS:

- Despite intensive research efforts, prevention is the only effective AIDS control strategy at present. Thus, there should be an aggressive Federal effort in AIDS education.
- The scope and content of the school portion of this AIDS education effort should be locally determined and should be consistent with parental values.
- The Federal role should focus on developing and conveying accurate health information on AIDS to educators and others, not mandating a specific school curriculum on this subject, and trusting the American people to use this information in a manner appropriate to their community's needs.
- Any health information developed by the Federal Government that will be used for education should encourage responsible sexual behavior—based on fidelity, commitment, and maturity, placing sexuality within the context of marriage.
- Any health information provided by the Federal Government that might be used in schools should teach that children should not engage in sex, and should be used with the consent and involvement of parents.

PREFACE TO THE THIRD PRINTING

Since the release of *AIDS and the Education of Our Children* in October 1987, over 1.5 million copies have been distributed or requested. As promised in the original Introduction, this new printing has been revised to provide the most reliable information currently available. While unchanged in its message, the new printing does update factual information about the extent of the AIDS virus infection and AIDS mortalities. In addition, the list of AIDS education resources in Part 3 has been expanded.

INTRODUCTION

Acquired immune deficiency syndrome, or AIDS, has claimed about 28,000 lives in the United States, and it is expected to claim millions more worldwide over the next few years. It is estimated that as many as 1.5 million Americans are infected with the virus that causes AIDS, but most of them do not know they are infected.

AIDS poses special problems and concerns for parents, teachers, and other adults responsible for the upbringing of children. Because so many of these adults have expressed to me a desire for guidance on how to talk to children about AIDS, they are the primary audience for this booklet. *AIDS and the Education of Our Children: A Guide for Parents and Teachers* offers the most accurate information currently available on the AIDS virus: what AIDS is, how it is spread, how people can reduce the risk of contracting it. It addresses the issues and the questions that many parents and teachers face in talking to children about AIDS. I hope this booklet will help them do so in a manner consistent with their moral principles and with the best interests of their children.

The fight against AIDS must have three fundamental goals. First, we must do all we can to find a cure for AIDS and a vaccine against the virus. Second, we must care for all victims of the disease; this care must include protecting them from injustice and persecution. Finally, we must take appropriate measures, such as routine testing and effective education, to protect the public health.

It has been less than a decade since AIDS first appeared in the United States. In that short time, considerable progress has been made in the fight against the disease. Thanks to our medical researchers, the virus that causes it has been identified, a blood test for the AIDS antibody has been developed, and extensive research efforts have been initiated to find drugs to treat the disease and to create a vaccine to prevent it. We do not yet have a cure, but the means to find one as quickly as possible have been put into place.

Education has played an important part in the battle against AIDS, and it must continue to do so. The Federal Government and many state governments and localities have launched AIDS education programs for the public and for young people in schools. Adults need to know the facts, the often unwelcome facts, about AIDS. They need to know what kinds of behavior put them and their children at risk of contracting AIDS. And they need to know what measures offer real protection and what measures offer false security.

The key fact young people need to know is this: there is much they can do to avoid contracting AIDS. Most cases of AIDS result from behavior that can be avoided. AIDS is primarily spread by having sexual contact with an infected person or by sharing hypodermic needles or syringes with an infected person. Avoiding such behavior greatly reduces the chances of becoming infected. Individuals are not powerless against the threat posed by AIDS. We can protect our young people, and the way to protect them is to tell them the truth and to teach them to act responsibly.

Because AIDS is most commonly spread by intimate sexual activity with an already infected person, AIDS is one more reason to examine what we are teaching our children about responsibility and sexuality. They need to know, in a way that is appropriate to their age and experience, the facts about the disease. They need to know how to avoid contracting AIDS. They need to be able to distinguish between rational fears and irrational fears. In speaking to young people about sexual activity and AIDS, parents and other adults responsible for young people's well-being must tell the truth. The task of adults is to show the way to responsible sexual behavior. And adults must be truthful about the risks and dangers—moral, physical, and psychological—of irresponsible sex, of heedless, careless use of one's own or another person's body.

In regard to AIDS specifically, responsible adults will counsel young people against premature sexual activity—that is, against engaging in sexual activity before achieving maturity, before acquiring an understanding of the seriousness of what is involved, before achieving respect for oneself or others, before being willing and able to accept responsibility for one's actions. Among many other reasons for discouraging premature sexual activity—in addition to the reasons adults have traditionally offered and still should offer—AIDS offers one more compelling reason. The stark message is this: if you have sex with a partner infected with AIDS, there is a chance you will get the virus and that you will die from it.

AIDS and the Education of Our Children is an effort to present the facts as clearly as possible. This task was difficult in light of the sensitive topics which are addressed and the limited extent of available knowledge about some aspects of AIDS and the AIDS virus infection. This publication will be revised as we learn more about the disease.

William J. Bennett
Secretary of Education
October 1987

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PART 1: FACTS ABOUT AIDS

What Is AIDS?

AIDS (acquired immune deficiency syndrome) is a disease caused by a virus that destroys a person's defenses against infections. These defenses are known as the immune system. The AIDS virus, known as human immunodeficiency virus, or HIV, can so weaken a person's immune system that he or she cannot fight off even mild infections and eventually becomes vulnerable to life-threatening infections and cancers.

The exact origin of AIDS is unknown. The disease was first noted in the United States in the late 1970's and early 1980's. The tracing of AIDS began only when doctors had seen enough of it to recognize that they were faced with a serious, previously unknown disease. It was formally defined for the first time in 1982.

By 1981, doctors had identified 266 people in the United States with AIDS. By December 21, 1987, there were 49,342 Americans diagnosed as having AIDS. Medical officials believe that the actual number of persons with the disease is higher. Some under-reporting occurs; a study by the Centers for Disease Control estimated that the actual number of AIDS cases is about 10 percent higher than the number officially identified.

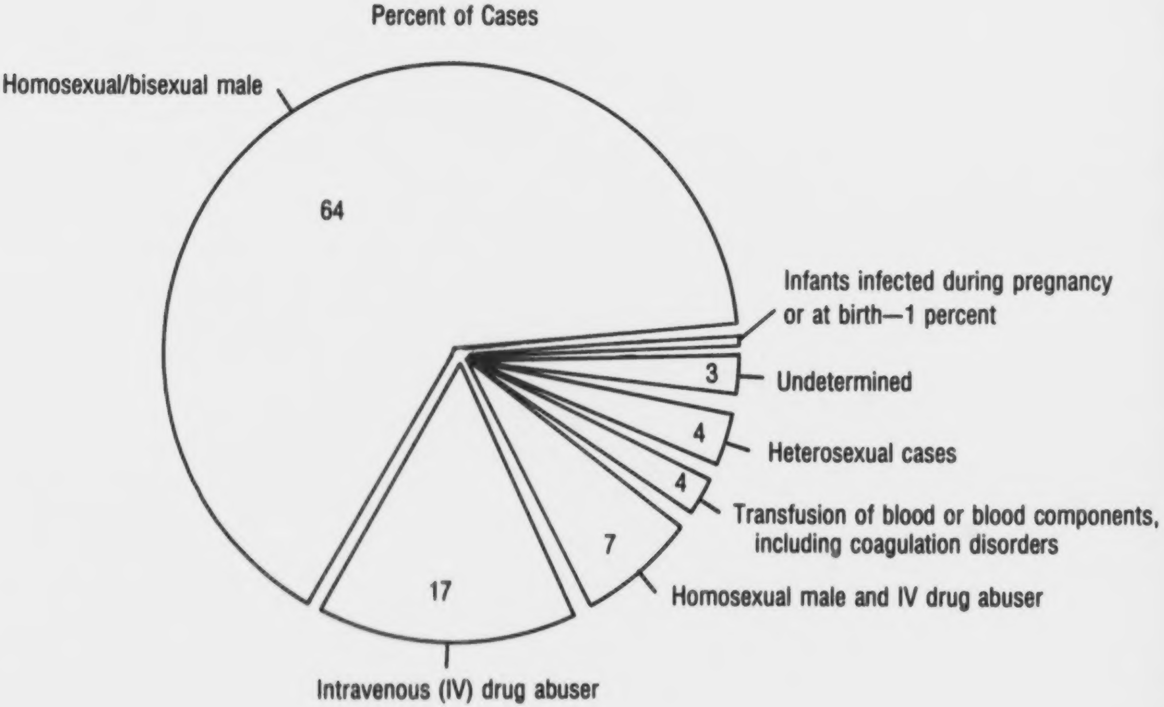
Moreover, AIDS only represents the end-stage disease caused by the virus. The number of people who are infected with the AIDS virus but have not developed the disease is now estimated to be as large as 1.5 million.

As of December 21, 1987, only 21,578 of the 49,342 victims of the disease were still alive. Every state has reported at least one AIDS case, and 33 states, the District of Columbia and Puerto Rico have reported at least 100 cases. Most of the reported cases of AIDS are concentrated in metropolitan areas. In fact, three-fifths of all cases are in 10 cities: New York; San Francisco; Los Angeles; Houston; Washington, D.C.; Miami; Newark; Chicago; Dallas; and Philadelphia.

The AIDS virus is transmitted through the exchange of infected body fluids. Some 88 percent of persons known to have AIDS are homosexuals or intravenous drug abusers; 1 percent are infants who were infected by their mothers during pregnancy or at birth; 4 percent became infected through blood transfusions before the Red Cross and other centers began testing blood for the AIDS antibody in 1985; and for 3 percent, the cause is undetermined (see Chart 1).

Only 4 percent of known AIDS patients became infected with the disease through heterosexual con-

CHART 1 — Mode of Transmission for Persons with AIDS



SOURCE: "AIDS Weekly Surveillance Report," Centers for Disease Control, December 21, 1987.

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tact, although almost half of these came to the United States from foreign countries with high AIDS infection rates. Some health officials estimate that by 1991 the number of AIDS cases acquired through heterosexual contact will increase to 6 percent of all cases. This, however, is still a matter of debate within the medical community.

Black and Hispanic young people have been much more affected by AIDS than young whites. Although they make up only 23 percent of the U.S. population between 5 and 19, they make up 52 percent of the reported cases in that age group. Eight out of ten children under the age of 5 with AIDS are black or Hispanic.

It is estimated that by 1991 a total of 270,000 persons will have developed AIDS in the United States (with 74,000 cases occurring in 1991 alone) and almost 179,000 Americans will have died from AIDS.

Symptoms of AIDS Virus Infection

The AIDS virus reduces the ability of the body's immune system to protect against disease. In addition, the virus may attack the nervous system and result in damage to the brain. The AIDS virus may initially cause a wide range of symptoms, including chronic episodes of the following:

- Fever
- Night sweats
- Diarrhea
- Weight loss
- Fatigue
- Swollen lymph glands
- Skin rashes
- Neurologic disorders such as dementia, memory loss, partial paralysis, and loss of coordination

Pneumonia, cancers, and other illnesses—many of them otherwise rare—may develop as a result of the damage done to the immune system by the AIDS virus. These illnesses are serious, difficult to treat, and often recurrent. Many patients die within 2 years of the appearance of the disease. Persons infected with the AIDS virus have developed symptoms of AIDS as early as 4 months or as late as 8 or more years after becoming infected. There have been no recorded cases of prolonged remission of AIDS.

No Cure or Vaccine for AIDS

At the present time, there is no vaccine to prevent people from becoming infected with the AIDS virus. Many of the illnesses caused by the AIDS virus are treatable, but the AIDS infection itself cannot be cured and can be expected ultimately to lead to illnesses that prove fatal.

Much research is being conducted to develop experimental vaccines as well as experimental drugs such as zidovudine (previously known as azidothymidine, or AZT), which is believed to delay the progression of the disease. But scientists believe that it may take many years before a proven vaccine to prevent AIDS or proven treatments to cure the disease might be available.

How Is the AIDS Virus Transmitted?

Common Ways of Transmission

The AIDS virus is most commonly transmitted through male homosexual intercourse with an infected partner and through the sharing of intravenous drug needles or syringes with an infected person. It can also be transmitted by heterosexual intercourse with an infected partner. Because the AIDS virus, when present, is contained in some body fluids (mainly blood, semen, and vaginal secretions), actions that involve the exchange of these fluids between people greatly increase the chances of passing the virus to another person. Women infected with the AIDS virus may also transmit it to their children during pregnancy or, later, during breast-feeding.

Because the AIDS virus can be transmitted by the transfusion of blood or certain blood products, hemophiliacs and other recipients of transfusions or blood products were at very substantial risk of becoming infected. However, since 1985, donated blood has been screened by a new test that can identify blood containing antibodies to the AIDS virus. The chance now of getting AIDS from a transfusion is very small.

The AIDS virus has also been found in saliva, tears, breast milk, and urine. However, on the basis of current medical research, the chances of becoming infected with the AIDS virus by coming into contact with these body fluids and wastes are small, certainly far smaller than through the usual routes of sexual intimacy and intravenous drug use.

The Public Health Service to date has stated there is no evidence to suggest a risk of contracting the AIDS virus from day-to-day social or family contact with someone who has AIDS. A number of studies have evaluated a total of nearly 500 family members of AIDS patients for evidence of infection. None of the uninfected family members became infected with the AIDS virus through casual contact or by sharing kitchen and bathroom facilities with the family member carrying the virus.

Unknowing Transmission

It is not currently known how many of the persons infected with the AIDS virus will develop the disease. Most experts estimate that more than 50 percent of those now infected with the virus will develop the disease over the next 10 to 15 years. ***Regardless of whether the symptoms of AIDS are apparent, anyone who is infected with the AIDS virus must be presumed to be capable of transmitting the virus to someone***

else. Persons who do not have the symptoms of AIDS but are capable of infecting others pose a serious risk to their sexual partners. Although it cannot provide a cure today, medical science has provided information about the transmission of AIDS and a highly accurate testing procedure for the infection with which the unknowing transmission of AIDS can be greatly reduced.

How Are Adolescents at Risk of Contracting AIDS?

Teenage Sexual Activity

Statistics show that sexual activity increases dramatically during the teenage years. By age 15, 16 percent of boys and 5 percent of girls in the United States have had heterosexual intercourse at least once. By age 17, these rates almost triple for boys and increase 5 times for girls. Nonetheless, ***at age 17 over one-half of all teenagers have not been sexually active*** (see Chart 2). The incidence among teenagers of homosexual activity, the most common mode of transmission of the virus, is not known.

Research also shows that most teenagers are not using condoms, which provide some but by no means complete protection from the AIDS virus. In a 1986 survey of 1,000 teenagers, the majority (53 percent) of sexually active teenage boys did not use condoms.

Increased sexual activity among teenagers has contributed greatly to their high rates of contracting sexually transmitted diseases such as gonorrhea and syphilis (see Chart 3). This increased sexual activity also makes the transmission of AIDS more likely. More than 6 out of 10 persons with gonorrhea or syphilis are less than 25 years old—that is, 581,913 out of a total of 938,038 cases in 1985. The Centers for Disease Control reported that in 1985:

- One out of four persons with gonorrhea or syphilis (25 percent) was between 10 and 19 years old.
- Almost 4 out of 10 persons with gonorrhea or syphilis (37 percent) were between 20 and 24 years old.

Teenage Drug Abuse

Drug abuse is, unfortunately, quite widespread among American school children. Over half of high school seniors have used illicit drugs, though only a small percentage of teenage drug users use intravenous drugs and risk contracting AIDS in this way.

- About 8 percent of all cocaine users have injected the drug intravenously. In addition to cocaine, other drugs that may be taken intravenously are amphetamines and other stimulants, hallucinogens such as phen-

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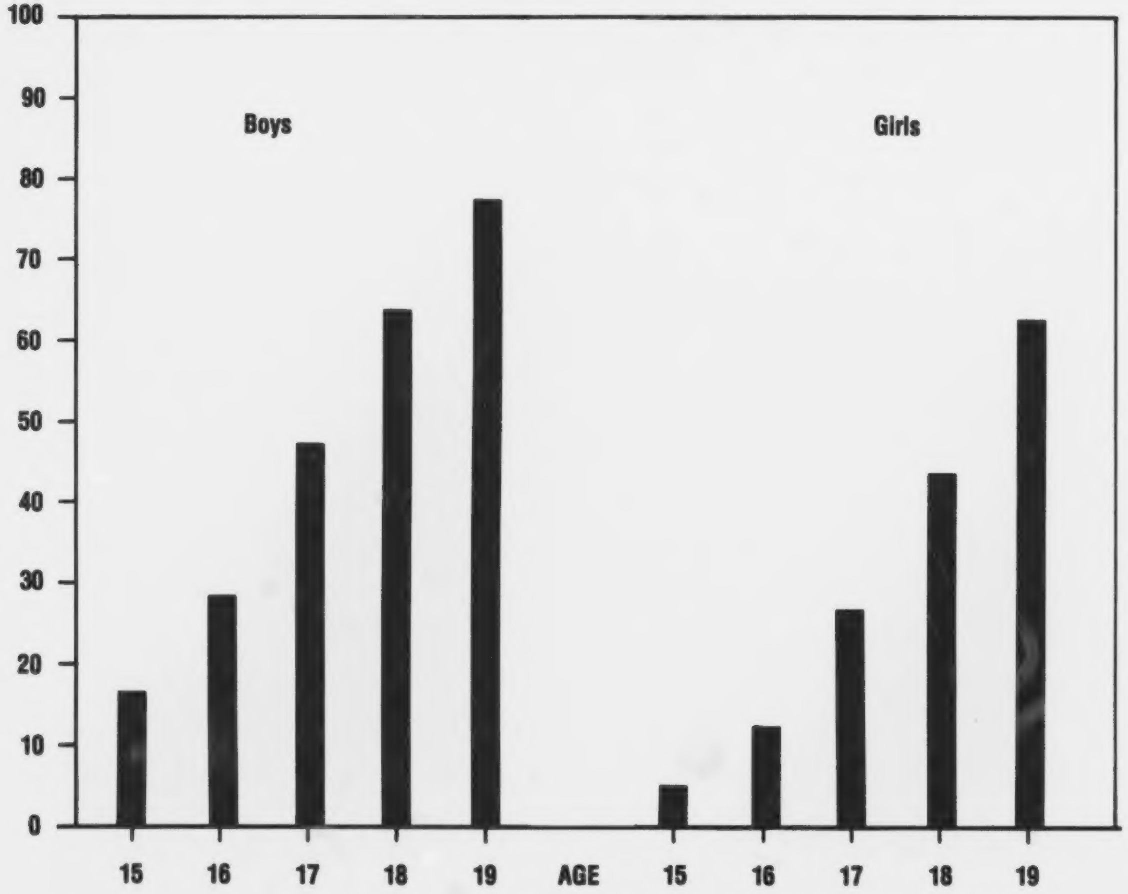
CHART 2 — Percentage of Boys and Girls 15 to 19 Years Old Who Have Had Heterosexual Intercourse



SOURCE: Tabulations from the 1982 National Longitudinal Survey of Youth by the Center for Human Resource Research, Ohio State University, 1983. In *Risking the Future*, National Academy Press, 1987.

cyclidine (PCP), most narcotics (e.g., heroin), and many "designer" drugs, which are slight chemical variants of existing illegal drugs.

- Although most intravenous drug users are age 25 to 45, more than 20,000 teenagers have used drugs intravenously. And most older intravenous drug users have a history of involvement with illegal drugs that began in their teens with the use of nonintravenous drugs. The use of any illegal drug is dangerous in itself and the use of one illegal drug often leads to the use of others.

Inadequate Information

Many teenagers do not know the basic facts about AIDS. Recent surveys have demonstrated the need for teenagers to be made aware of the activities that put them at risk of contracting AIDS.

A study of young people in San Francisco in 1986 revealed that:

- Thirty percent believed that AIDS could be cured if treated early.
- One-third did not know that AIDS cannot be transmitted by merely touching someone with AIDS or by using a friend's comb.

In addition, a study in 1986 of 860 Massachusetts teenagers aged 16 to 19 found that 22 percent did not know that AIDS can be transmitted by semen and 29 percent were unaware that it can be transmitted by vaginal secretions.

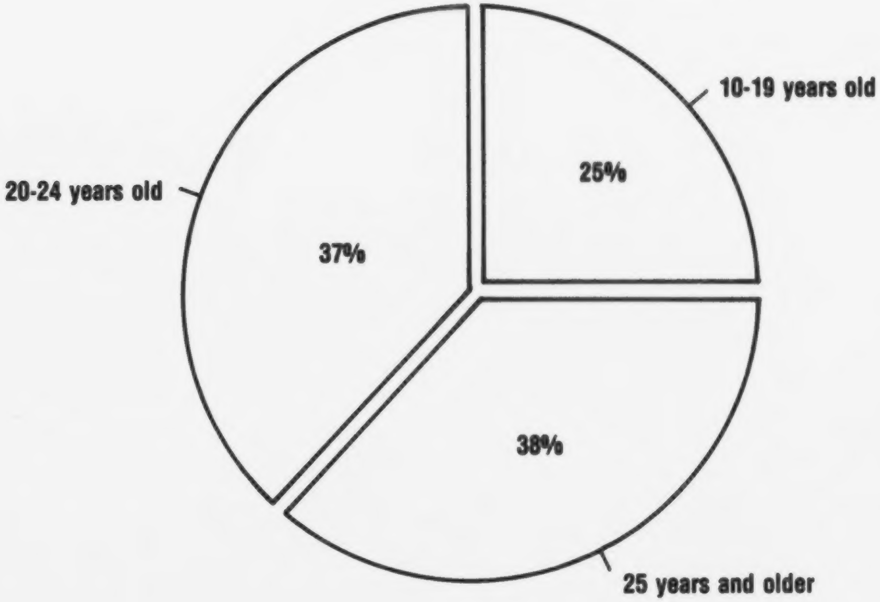
The Limits of Information and Education

Young people should be told the facts about AIDS, but information alone will not adequately protect them. In a recent survey of 458 University of Maryland students about their knowledge of AIDS and sexual behavior:

- Seventy-seven percent said that they knew that condoms can be used to limit the risk of infection of AIDS, but only 30 percent of those who used condoms reported increased use of condoms.
- Eighty-three percent of the male students who said they had homosexual relations said that they had made no change in their behavior.

Nothing can substitute for individual responsibility. As the National Education Association guide, *The Facts About AIDS*, states: "Health education that relies only on the transmission of information is ineffective. Behavioral change results only when information is supported by shared community values that are powerfully conveyed." We must give young people the facts, but we must remember it is their sense of right and wrong, their internal moral compass, that determines their actions.

CHART 3 — Distribution of Persons With Syphilis or Gonorrhea By Age



SOURCE: Centers for Disease Control, Sexually Transmitted Disease Cases Reported, 1985.

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PART 2: PROTECTING OUR CHILDREN FROM AIDS

What Is to Be Done?

The surest way to prevent the spread of AIDS in the teenage and young adult population is for schools and parents to convey the reasons why adolescents should be taught restraint in sexual activity and why illegal drug use is wrong and harmful. Although messages urging responsibility and restraint have been given before, the emergence of the AIDS threat gives them even greater importance.

We here offer four principles of AIDS education to guide parents, schools, and the community in educating our children and helping them combat the disease of AIDS.

1. Help Children Develop Clear Standards of Right and Wrong

Studies have shown that children who firmly hold to the principles of appropriate moral and social conduct are less likely to act in ways that would place them at risk of becoming infected with AIDS. The most important determinant of children's actions is their understanding of right and wrong. Parents, schools, and community organizations that work with children must instill firm standards of conduct that include respect for personal well-being and the well-being of others. Children should be taught the importance of self-discipline and personal responsibility by holding them accountable for their actions. They should also be brought to understand that, as young adults, they will bear the primary responsibility for protecting themselves from becoming infected with the AIDS virus.

Actions:

- **Teach restraint as a virtue.** Parents and school personnel should teach children restraint as a standard to uphold and follow. Explain the positive benefits of responsible behavior as well as the fact that the safest and smartest way to prevent infection with the deadly AIDS virus is to avoid premarital sex and illegal drugs. Even the use of nonintravenous drugs, such as marijuana and alcohol, can lead children toward activities that would expose them to the risk of being infected with AIDS.
- **Present sex education within a moral context.** Parents want the schools to teach the difference between right and wrong in sex education and elsewhere. Parents want sexuality taught within a moral framework. In a

"Community of Caring"

The Joseph P. Kennedy, Jr. Foundation established a network of Community of Caring programs 11 years ago to help combat the problems of adolescent sexual activity and teen pregnancy. The program originally focused on helping pregnant teenagers have healthy babies, but has expanded into other areas of concern—especially pregnancy prevention. A new curriculum, "Growing Up Caring," has recently been implemented in five school systems. The curriculum is based on the belief that teenagers become sexually active because they have not perceived their sexuality in a moral context. The program operates on the premise that any time sex education is taught, it must be taught within the context of family and ethical values.

"Growing Up Caring" contains a section dealing with AIDS in its teaching units for teachers, parents, and other instructional personnel. Its discussions and activities emphasize morality and responsibility. For example, in the section on drug abuse, a point is made that teenagers are responsible not only for their health now but also for their future health and their ability to become productive citizens and to establish strong and healthy families of their own.

The curriculum is designed to encourage students to work hard and develop good character. The themes of the curriculum include the following:

- **Family.** The curriculum teaches that the family provides the major ethical framework for a child.
- **Personal responsibility.** Adolescents are taught how to assume responsibility for themselves.
- **Commitment to parenthood.** Young men and women are taught the skills and commitment needed to meet the challenge of pregnancy and parenthood.
- **Responsible sexuality.** By drawing on values that include love, concern for others, responsibility to family members, truth, productive hard work, and the wholesomeness of sexuality, adolescents are shown a basis for their future sexual decisions.
- **Planning for future goals.** The curriculum shows how adolescents can redirect their lives through planning. The hope is that the young people will form constructive and attainable goals.

national poll, 70 percent of the adults surveyed said they thought that sex education programs should teach moral values. About the same percentage believed sex education courses should urge students not to have sexual intercourse.

- **Speak up for the institution of the family.** Fidelity and commitment should be positive goals toward which all of our children should strive. Unless a marriage partner is infected before marriage or uses intravenous drugs, persons in mutually faithful and monogamous relationships are protected from contracting AIDS through sexual transmission.
- **Set clear and specific rules regarding behavior.** Parents and teachers must clearly establish appropriate standards of behavior and convey them to children in the home and school. Setting high standards of behavior and holding young people accountable for their actions will help them take responsibility for their behavior, and it will help them develop respect for others and for themselves.

2. Set a Good Example

Parents and school personnel should be aware that they very much influence young peoples' behavior. Adults who try to live in accordance with moral standards, take care of their health, and engage in a monogamous relationship provide an example to young people of how to avoid the risks of contracting AIDS.

Actions:

- **Demonstrate moral standards through personal example.** Adults must try to live up to the ideals they set for themselves and their children. They should cite concrete examples from everyday life, discuss the moral issues they confront, and describe how they find the strength to follow their ideals. Parents should put their children in contact with other adults whose lives will be a good example to young people.
- **Follow the principles of good health.** Adults who follow a healthy diet, exercise, and generally show a concern for their own well-being help children learn how to care for themselves. Similarly, adults who abuse their bodies—for example, through the use of illicit drugs—may influence children to follow their example. Adults who do not show restraint in their own lives are unlikely to be successful in teaching children how to be responsible.
- **Demonstrate responsibility for others in personal relationships.** By the relationships they establish with children, their families, and other adults, parents and teachers show children how they expect them

''Postponing Sexual Involvement''

''Postponing Sexual Involvement'' is a ''How to Say No'' program targeted to 13-to-15 year olds and their parents. The program is taught in Atlanta schools and is being implemented throughout Georgia. The program was developed to help adolescents resist pressures to become sexually active. It consists of a series of 4 one-hour sessions and a follow-up session. Program coordinators train older teenagers as peer leaders who conduct the sessions. ''Postponing Sexual Involvement'' does not simply present information but gives teenagers the tools and skills they need to handle the reality of their sexuality. It also identifies the sources of societal pressures that are often responsible for early sexual activity. Parents receive a shortened version of the lessons.

The results of the series are promising. In the pilot program with 1,000 teenagers:

- Seventy percent said the series taught them adolescents can decide to postpone sex without losing the respect of their friends.
- Sixty-three percent of the adolescents said they felt it was easier for them to express their point of view regarding sexual involvement after attending the series.
- Seventy-eight percent of the participants said they would recommend the series to a friend.
- Thirty-three percent said the series made them aware of the fact that most teens do indeed say no to early sexual involvement.

to act. Adults who show concern for the well-being of others help prevent the spread of AIDS through their respect for others.

3. Help Children Resist Social Pressures to Engage in Dangerous Activities

Peer pressure is one of the strongest influences encouraging students to engage in promiscuous sex and drug use. In addition, older students who have already engaged in these practices reinforce the view that sexual intimacy and drug use are the norm. Adults must counteract these influences.

Actions:

- **Help students identify negative pressures.** Schools, religious institutions, and community organizations can sponsor programs that help students identify pressures in their lives that direct them into risky behaviors. Such programs can help young people develop and practice strategies to combat these pressures.

- **Be attentive to children's behavior inside and outside of school.** Parents should be attentive to their children's school and social lives by paying attention to their children's dating, friendships, school programs, and television viewing.

- **Encourage students to provide a good example to their peers.** Students can positively influence their peers through their attitudes and everyday behavior. If student leaders take stands against irresponsible behavior, other students will be more likely to follow their lead. Students can also persuade their peers who indulge in dangerous behavior to seek adult help in combating their problems.

- **Be able to discuss drugs knowledgeably.** In order to provide guidance and to support children in resisting drugs, parents must be knowledgeable about drugs and their effects. It is better for children to obtain information about drug use from their parents than from their peers.

4. Instruct Children About AIDS

Many young people remain largely ignorant about AIDS. Some American teenagers are risking infection with the AIDS virus every day because of their involvement in high-risk activities that transmit the disease—sexual relations and illicit drug use. To prevent the spread of AIDS among young people, parents, schools, and communities should teach children about the deadly disease. The dual messages of responsibility and restraint must be integral parts of any education effort.

"Responsible for Myself"

Believing that today's young people need to learn about responsible behavior through systematic instruction rather than by chance, at San Marcos Junior High School (San Marcos, California), the staff, parents, and community members put together a program to encourage students to be responsible for themselves. Focusing on specific teenage problems such as sexual activity, drug use, poor self-esteem, and poor study habits and decision-making skills, the planning group designed a program titled "Decision Making—Keys to Total Success."

The program is required of all seventh and eighth grade students and is offered in the following sequence:

- **Study skills and test taking.** Emphasizes the acquisition of appropriate study and test-taking skills. The information is covered in the first 6 weeks of the semester.
- **How to be you.** This section focuses on self-esteem, value-based instruction, and decision-making skills. The information is covered during 6 weeks of the second semester.
- **Sexuality, commitment, and family.** This part teaches children that abstinence is the only sensible way for teens to deal with sex. It seeks to instill appreciation for the creation of life, as well as understanding that parenthood is a rewarding commitment made by responsible people. Negative peer pressure and media influence are also discussed. The information is covered in the last 6 weeks of the second semester for 8th graders.
- **How to be successful in less than 10 minutes a day.** Incorporates the themes of the other programs, stressing personal responsibility, good academic behavior, respect for self and others, persistence, and courtesy. The drug abuse prevention program is taught as part of this component and links effective drug resistance strategies to the values on which this program is based. This component is covered daily in 8-minute segments during the homeroom.

According to the principal at San Marcos, personal responsibility is the key to success for his students. Reinforced by the school's motto, "I am responsible for myself," the program has helped students strengthen their character as well as gain personal insight. ***The program helped reduce adolescent pregnancies significantly—from 147 in school year 1984-85 to 20 in school year 1986-87.***

Actions:

- **Provide the facts about AIDS.** Parents and schools should provide up-to-date information about what the AIDS virus is and how it is spread. Ordinarily, in the schools, this would be a part of sex education, which generally begins in junior high school. Young people should know that they risk contracting the disease if they engage in sexual contact or intravenous drug use with infected persons.

- **Talk to children about their fears.** Children, even at a young age, are exposed to information about AIDS. Television commercials, news broadcasts, and casual conversations will give them bits and pieces of the AIDS story that may frighten them without informing them. What they hear may cause them to believe that contracting AIDS is inevitable or, conversely, impossible. Adults need to help children articulate their fears and help correct their misperceptions.

  Discussing AIDS also can enable young people to understand the disease and the suffering experienced by its victims. In learning how to avoid AIDS, young people can also learn to have compassion for the affliction of others.

- **Teach about sex in a way that emphasizes the reasons for abstinence, restraint, and responsibility.** Many sex education programs fail to provide a message of personal responsibility. Some present sex mechanistically, answering questions about how sex works and how it can be made to serve a variety of purposes (e.g., self-gratification). Other programs contain value-neutral discussions of sexual relations in which the teacher makes a concerted effort not to make moral judgments about sexual activity.

  Responsible sex education courses should not hesitate to teach children that sexual restraint is the best standard to follow. Sexual intimacy should be presented as more than merely a physical or mechanical act.

- **Get the community involved in AIDS education.** Civic groups, churches, local health departments, and the medical community should be enlisted in educating the young people in their community about AIDS. The community must first become informed about the risks involved in acquiring and transmitting the AIDS virus infection and then present a consistent message to its young people that emphasizes the risks involved in promiscuous sex and illicit drug use.

- **Teach drug prevention to children.** Drug prevention efforts should be an integral component of all educational programs.

Condoms and AIDS

The use of condoms is now frequently recommended as a means of reducing the risk of both contracting AIDS and spreading the disease. Many people, for moral or religious reasons, oppose encouraging the use of condoms. Others are eager to make condoms widely available, even or especially to young people. In any case, if the use of condoms is to be discussed with young people, such a discussion must include the recognition of certain facts, should take place with the approval of parents, and should occur in an appropriate moral context. In particular, young people must know that ***the use of condoms can reduce, but by no means eliminate, the risk of contracting AIDS.***

Condoms can and do fail. The use of condoms can reduce the risk of infection when engaging in sexual activity, but they must be used from start to finish and in a manner that prevents any exchange of bodily fluids. Even then there is no guarantee of safety.

When condoms are used for contraceptive purposes, they fail about 10 percent of the time over the course of a year. Some experts think that condoms are much less effective as a means of stopping the transmission of the AIDS virus. According to a recent study at the University of Miami Medical School, 17 percent of the women whose husbands with AIDS used condoms became infected themselves within 18 months, despite the use of condoms. And the Surgeon General has also warned that condoms have "extraordinarily high" failure rates among homosexuals.

Maintaining a moral context. Any discussion of condoms must not undermine the importance of restraint and responsibility in the minds of young people. It is important to remember that condoms have long been widely available and that most teenagers know about them, yet the teen pregnancy rate has still risen. This is not only because condoms do fail, but also because teenagers who know about condoms often fail to use them. Teenagers' beliefs and convictions about proper sexual behavior are more effective in shaping their behavior than mere knowledge about devices such as condoms. Indeed, promoting the use of condoms can suggest to teenagers that adults expect them to engage in sexual intercourse. This danger must be borne in mind in any discussion.

Schools, religious institutions, and youth organizations should emphasize that drug use is wrong and harmful. Efforts should be geared to strengthening a child's resistance to drugs. For teenagers, a clear link between drug use and AIDS should be made. Children must learn that not taking drugs will reduce the possibility of becoming infected with the disease.

- **Find appropriate opportunities to discuss AIDS.** The topic of AIDS, involving as it does issues of sex and drug use, is an uncomfortable one to raise. Yet a one-time family discussion or a special AIDS curriculum unit or school assembly is not enough to prevent the spread of AIDS among young people. Adults need to find appropriate occasions to raise the issue with children—for example, when they are watching television programs that glamorize sex and illegal drugs or news programs that discuss AIDS, or when they are reading newspaper articles about AIDS.

Guidelines for Selecting Educational Materials on AIDS

Materials for use in teaching young people about AIDS must be selected and developed with the approval of parents. In addition, they should meet the following guidelines:

- **Teach about high-risk behaviors.** Teenagers and young adults are at greater risk of AIDS than much of the population because of their high levels of sexual intercourse and their use of illicit drugs. This point must be made clear.

- **Present the facts in a straightforward manner.** Facts on AIDS should be accurate and current. Information should be conveyed in straightforward language that students will understand. It should honestly portray what we do and do not know.

- **Emphasize standards of right and wrong.** Instruction about AIDS must include more than basic medical information. It must be based on clear standards of individual responsibility.
  — Materials should set positive standards; they should emphasize that young people can avoid premarital sex and drug use.
  — Materials should not be value neutral. Young people should be told that the best way to prevent the sexual transmission of AIDS is to refrain from sexual activity until as adults they are ready to establish a mutually faithful monogamous relationship. AIDS education should confirm this message from the sex

education curriculum. AIDS education (as part of sex education in general) should uphold monogamy in marriage as desirable and honorable.

— Materials discussing illicit drugs should not condone "responsible use" or use of "soft drugs." All illicit drug use is wrong.

- **Select appropriate materials.** To teach about AIDS is to deal with sensitive topics. Instructional materials, therefore, must be appropriate to the age of the students being taught and to local community needs and values.

— Young children should not be given overly explicit and detailed explanations. For them, instruction should lay the foundation of moral action and good health and give limited attention to AIDS itself.

— Although materials for older children will deal specifically with AIDS, they should emphasize standing up for one's convictions and abstaining from premarital sexual relations and illicit drug use.

— Education materials for adolescents may, with parental consent, also include information to help them reduce the risks to themselves and to other people.

- **Promote parental involvement.** Materials should recommend how parents and communities can become involved in the AIDS discussion. Parents and community members should be involved in the selection of materials and curriculum programs.

In deciding how to teach children about AIDS, school personnel should review the entire curriculum to find the most appropriate places for including this topic. All members of the school staff should be informed about AIDS and about ways to present the subject to children.

Children With AIDS in the Schools

To date, there have been no reported cases of the transmission of AIDS in the school setting. The U.S. Public Health Service and the American Academy of Pediatrics have stated that, in most cases, children with AIDS should be permitted to attend school. However, they do advise school administrators that children with AIDS who lack control over bodily functions, have open wounds or cuts, or display behavior such as biting, should receive individualized instruction outside the classroom.

Because of their weakened immune systems, children with AIDS or the AIDS virus who attend school are more likely to get common childhood infections—such as the flu, colds, and chicken pox—than children who do not have AIDS. After they contract these routine childhood illnesses, they have a greater chance of developing complications.

They may also be more likely to have more serious contagious diseases, such as hepatitis or tuberculosis. In addition, children with AIDS might not be permitted by their doctors to have routine vaccinations, because these vaccinations may place the children at risk of contracting the disease of the vaccine as a result of their impaired immune system. A child with AIDS should be under a doctor's supervision in order to assess periodically whether the child should remain in school.

Communities should take steps to ensure that medical information about persons who have AIDS (or who test positive for the virus) is kept confidential and used only for purposes of protecting the public health. Both the Education of the Handicapped Act (EHA) and the Family Educational Rights and Privacy Act contain prohibitions on unconsented disclosures of personally identifiable information about students. Disclosure of such information is permitted to appropriate school officials, if justified by public health or other legitimate considerations.

A number of states have passed laws that address requirements for reporting the AIDS virus for public health purposes and also for maintaining the confidentiality of such information. Other state legislatures are considering these issues. Accordingly, school officials are well advised to monitor developments in the law of their state on these matters.

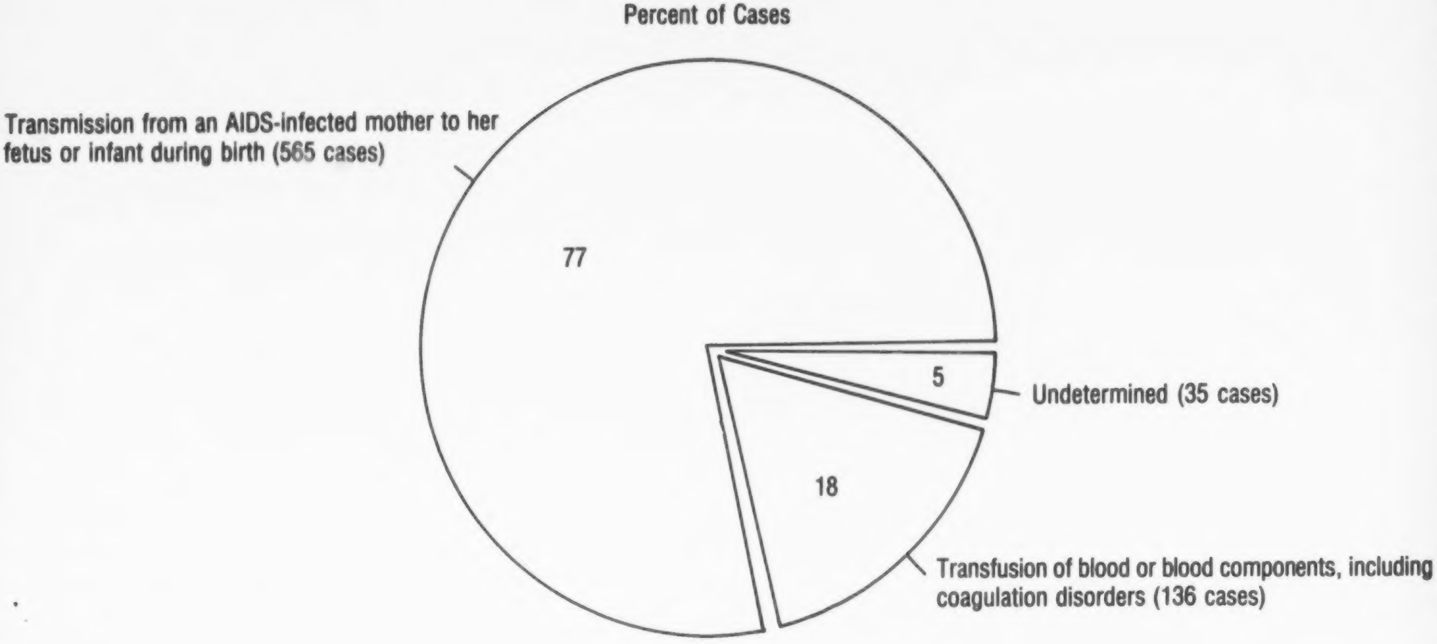
Questions have arisen about whether school districts are required to include children with AIDS in their regular education program or to provide special programs because of impairments due to AIDS. In 1987, the Supreme Court ruled in *School Board of Nassau County, Florida, et al.* v. *Arline* that persons with a handicapping infectious disease (in that case, tuberculosis) are covered by Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination against handicapped persons in programs that receive Federal funds.

Children whose health is impaired by AIDS, and because of that impairment need special education and related services, are also covered under the EHA, which guarantees a free appropriate public education to handicapped children.

In determining whether an individual child with AIDS should be served in its regular programs, a school district should take into consideration bona fide medical considerations about the likelihood of transmission to other children of the AIDS virus or of other infectious diseases the child may have as a result of AIDS. With respect to a child with AIDS who is served in its regular programs, these medical considerations may also justify a school district placing limitations on specific activities, such as sports, in which children participate. Similarly, decisions on placement should address whether the child will conduct himself or herself in a manner that will not endanger other children.

Chart 4 — Transmission Categories For Children With AIDS

(Includes All Patients Under 13 Years of Age at Time of Diagnosis)



SOURCE: "AIDS Weekly Surveillance Report," Centers for Disease Control, December 21, 1987.

School districts cannot, however, refuse to provide educational services to children with AIDS who are covered by the EHA or Section 504. Districts must also ensure that the services provided are appropriate for each child.

Children with AIDS may be absent from school more frequently than other children. During prolonged absences, education services must, under Federal law, be made available to children with AIDS. These may include home tutors as well as any other services provided by the school system to sick children.

Under the EHA and Section 504, placement decisions must be made by a team of persons knowledgeable about the child and based on medical and educational data concerning the child. For example, the team might include the child's parents, physician, teacher, public health personnel, and other appropriate education personnel.

Placement decisions must be based on the education needs of the child and reasonable medical judgments, given the current state of medical knowledge about risks to the child and others. For example, restricted placement may be advisable for children who lack control of bodily secretions, are at substantial risk of contracting serious illness, are likely to engage in behavior such as biting, or have open wounds. Under the EHA, the child's education program must be reviewed regularly to determine whether a change to the child's placement is required.

PART 3: SOURCES OF INFORMATION ABOUT AIDS

Toll-Free National Information

Public Health Service National AIDS Hotline (recorded message) 1-800-342-AIDS

A national information service that provides round-the-clock information on AIDS in English and Spanish. The 4-minute recorded telephone message outlines the methods of protection against the AIDS virus, mentions the blood tests that detect the AIDS virus (and where the tests are available), and provides information for women planning to become pregnant who are concerned about AIDS. The recorded message also provides the telephone number for contacting a hotline staff member for additional information (shown in the next listing).

The National AIDS Hotline (hotline staff) 1-800-342-7514

The Public Health Service operates this national resource and information service 7 days a week, 24 hours a day. In addition to providing information about AIDS, the staff refers callers to local and national hotlines and testing sites, and provides telephone listings for counseling, information about financial assistance, and other support groups. Free written materials are available upon request.

School and Community Resources

American Red Cross

This organization operates an AIDS Public Education Program intended to provide reliable, factual data to help prevent the spread of the disease. The Red Cross believes that adolescent health education should be based on positive values that rest on religious, ethical, legal and moral foundations. Educational materials are disseminated through more than 600 AIDS coordinators in local Red Cross chapters throughout the nation.

Available materials include pamphlets containing the latest facts about AIDS, such as guidelines for prevention programs for young people and information for parents of school-age children, teachers, and school officials. The Red Cross also has developed a four-part AIDS prevention program for junior and senior high school students which consists of a 25-minute videotape and printed supporting material. Information is available through local Red Cross chapters or through the American Red Cross, AIDS Education Program, National Headquarters, 1730 E Street, N.W., Washington, DC 20006, (202) 639-3223.

AIDS School Health Education Subfile

A computerized subfile of the Combined Health Information Database which contains information about AIDS programs, curricula, guidelines, policies, regulations, and other materials. Anyone who wants to locate this information must telephone Bibliographic Retrieval Service Information Technologies to obtain access to the data (1-800-468-0908) or write BRS Information Technologies, 1200 Route 7, Latham, New York 12110. The fee for obtaining a password and the time charge for searches vary. Discounts are available for school districts. Training on conducting database searches is available in most cities.

U.S. Public Health Service Recommendations for Education and Foster Care of Children

The following statements are excerpted from the guidelines developed by the Centers for Disease Control to help state and local health and education officials develop their own guidelines in light of community needs and concerns.

Risks to the Child with HIV Infection

HIV (AIDS) infection may result in immunodeficiency. Such children may have a greater risk of encountering infectious agents in a school or day-care setting than at home. Foster homes with multiple children may also increase the risk. In addition, younger children and neurologically handicapped children who may display behaviors such as mouthing of toys would be expected to be at greater risk for acquiring infections. Children with depressed immune systems are also at greater risk of suffering severe complications from such infections as chicken pox, cytomegalovirus, tuberculosis, herpes simplex, and measles. Assessment of the risk to the immunodepressed child is best made by the child's physician, who is aware of the child's immune status. The risk of acquiring infection such as chicken pox may be reduced by prompt use of specific immune globulin following a known exposure.

Recommendations:

1. Decisions regarding the type of educational and care setting for HIV-infected children should be based on the behavior, neurologic development, and physical condition of the child and the expected type of interaction with others in that setting. These decisions are best made using the team approach including the child's physician, public health personnel, the child's parent or guardian, and personnel associated with the proposed care or educational setting. In each case, risks and benefits to both the infected child and to others in the setting should be weighed.

2. For most infected school-aged children, the benefits of an unrestricted setting would outweigh the risks of their acquiring potentially harmful infections in the setting and the apparent nonexistent risk of transmission of HIV. These children should be allowed to attend school and after-school day-care and to be placed in a foster home in an unrestricted setting.

3. For the infected preschool-aged child and for some neurologically handicapped children who lack control of their body secretions or who display behavior such as biting, and those children who have uncoverable, oozing lesions, a more restricted environment is advisable until more is known about transmission in these settings. Children infected with HIV should be cared for and educated in settings that minimize exposure of other children to blood or body fluids.

4. Care involving exposure to the infected child's body fluids and excrement, such as feeding and diaper changing, should be performed by persons who are aware of the child's HIV infection and the modes of possible transmission. In any setting involving an HIV-infected person, good handwashing after exposure to blood or body fluids and before caring for another child should be observed, and gloves should be worn if open lesions are present on the caretaker's hands. Any open lesions on the infected person should also be covered.

5. Because other infections in addition to HIV can be present in blood or body fluids, all schools and day-care facilities, regardless of whether children with HIV infection are attending, should adopt routine procedures for handling blood or body fluids. Soiled surfaces should be promptly cleaned with disinfectants, such as household bleach (diluted 1 part bleach to 10 parts water). Disposable towels or tissues should be used whenever possible, and mops should be rinsed in the disinfectant. Those who are cleaning should avoid exposure of open skin lesions or mucous membranes to the blood or body fluids.

6. The hygienic practices of children with HIV infection may improve as the child matures. Alternatively, the hygienic practices may deteriorate if the child's condition worsens. Evaluation to assess the need for a restricted environment should be performed regularly.

7. Physicians caring for children born to mothers with AIDS or at increased risk of acquiring HIV infection should consider testing the children for evidence of HIV infection for medical reasons. For example, vaccination of infected children with live virus vaccines, such as the measles-mumps-rubella vaccine (MMR), may be hazardous. These children also need to be followed closely for problems with growth and development and given prompt and aggressive therapy for infections and exposure to potentially lethal infections, such as varicella.

In the event that an antiviral agent or other therapy for HIV infection becomes available, these children should be considered for such therapy. Knowledge that a child is infected will allow parents and others to take precautions when exposed to the blood and body fluids of the child.

8. Adoption and foster-care agencies should consider adding HIV screening to their routine medical evaluations of children who are at increased risk of infection. This should be done before placement in the foster or adoptive home, since parents must make decisions regarding the medical care of the child and must consider the possible social and psychological effects on their families.

9. Mandatory screening as a condition for school entry is not warranted based on available data.

10. Persons involved in the care and education of HIV-infected children should respect the child's right to privacy, including maintenance of confidential records. The number of personnel who are aware of the child's condition should be kept at a minimum needed to assure proper care of the child and to detect situations where the potential for transmission may increase (e.g., bleeding injury).

11. All educational and public health departments, regardless of whether HIV-infected children are involved, are strongly encouraged to inform parents, children, and educators regarding HIV and its transmission. Such education would greatly assist efforts to provide the best care and education for infected children while minimizing the risk of transmission to others.

Selected List of Publications About AIDS

The following list of materials illustrates some of the materials available for AIDS education.

***Educator's Guide to AIDS and other STD's* by Stephen R. Sroka, 1987.** The guide presents abstinence as the most effective method of preventing AIDS, and it emphasizes responsible sexual behavior and prevention of drug use. To help students avoid sex and drugs, many activities teach students how to respond in situations in which they may feel pressured into inappropriate behavior. In addition to providing effective strategies for AIDS prevention, the guide contains basic information about AIDS and sexually transmitted disease (STD) infections. Health Education Consultants, 1284 Manor Park, Lakewood, OH 44107, (216) 521-1766; $25.00.

***AIDS: What You Should Know* by Linda Meeks and Philip Heit, 1987.** This 27-page booklet is one of two in the Merrill Wellness Series. The booklet has student and teacher editions and is designed for use with 6th, 7th, and 8th graders. The booklet presents topically organized information on the origin of AIDS, virus transmission, risks, behaviors, virus detection, and treatment and research. The guide avoids explicit and detailed discussion of risky sexual practices and does not address the use of condoms. Students learn that abstinence is the most responsible decision they can make regarding both sexual activity and drug use. Students practice using the responsible decision-making model in various situations, and they learn how to avoid sex. All technical terms are clearly defined and key concepts are outlined in the margins. Merrill Publishing Company, P.O. Box 508, Columbus, OH 43216, 1-800-848-6205; $3.95 for student guide and $6.00 for teacher's guide. A discount is available to schools and other organizations.

***AIDS: Information/Education Plan to Prevent and Control AIDS in the United States*, 1987.** This 57-page book outlines a plan for informing and educating the nation about AIDS. The book identifies target audiences, basic elements of AIDS education and information, and suggests methods for conducting AIDS education programs. National AIDS Information Clearinghouse, Box 6003, Rockville, MD 20850.

***Instructional Outcomes for AIDS Education*, 1987.** Rhode Island has issued a set of curricular and programmatic recommendations for local school districts to follow when selecting an AIDS curriculum. Although these guidelines do not constitute a state-developed curriculum, they present criteria for evaluating an AIDS curriculum and the expected learning outcomes for each age group. Abstinence, individual responsibility, and resisting peer pressure are emphasized. Prepared jointly by the Rhode Island Department of Education and the Rhode Island Department of Health. Office of Health Information, State Department of Education, 22 Hayes Street, Providence, RI 02908, (401) 277-2651. Single copies are free.

Other Resource Materials

The following materials are selected from a wide range of resource materials available, including technical publications and information on related educational programs.

***Confronting AIDS: Directions for Public Health, Health Care and Research*, 1986.** A report by the Institute of Medicine of the National Academy for Sciences about the causes and transmission of AIDS, the epidemiology of conditions associated with AIDS, and recommended actions for combating the disease. Published by the National Academy Press, Washington, DC, and available from the National Academy Press Bookstore, 2101 Constitution Avenue N.W., Washington, DC 20418, (202) 334-3313; $24.95.

***AIDS: Impact on the Schools* by Roberta Weiner, 1986.** A 274- page book designed to provide factual information about how the disease is transmitted, how schools have been affected to date, AIDS litigation, and problems faced by colleges and universities. A special report from the Education

Research Group, Capitol Publications, 1101 King Street, Alexandria, VA 22314, (703) 683-4100; $45.50.

***Saying No and Meaning It: A Guide for Parents* by the National Urban League, 1986.** This 40-page guide is designed to help parents talk to their children about abstaining from premature sexual activity. Parents participate in 3 workshops that address several issues related to adolescent sexuality and help them improve parent-child communication skills. The Urban League offers guidance to community volunteers who want to lead parent groups. Copies of the guide and other information can be obtained from the National Urban League, Inc., 500 East 62nd Street, New York, NY 10021, (212) 310-9238; $5.50.

***Sex Respect: The Option of True Sexual Freedom* by Coleen Kelly Mast, 1986.** This curriculum teaches junior and senior high school students about the emotional, physical, and psychological risks associated with adolescent sexual activity. Emphasis is placed on developing decision-making and refusal skills which can help teens choose not to be sexually active or, for sexually active teens, to become abstinent. The curriculum materials consist of a teacher's manual ($12.95), a parent guide ($10.95), and a student workbook ($7.95). A preview package containing one copy of each book is also available ($28.50). Add $3.50 to the order for shipping and handling. These materials are available from Project Respect, Distribution Center, P.O. Box 97, Golf, IL 60029-0039; (312) 729-3298.

***Training for Life* by the Margaret Hudson Program for School-Age Parents, 1986.** This program trains volunteer leaders to work with parent support groups in order to improve family communication and to help adolescents postpone sexual activity until marriage. Parents attend 4 workshops dealing with topics such as family values, decision-making and refusal skills for adolescents, and adoption as a viable option for pregnant teens. Contact the Margaret Hudson Program for School-Age Parents, P.O. Drawer 6340, Tulsa, OK 74148, (918) 585-8163; $5.00.

***What Works: Schools Without Drugs*, 1986.** This U.S. Department of Education handbook recommends approaches for stopping drug use in America's schools. The guide describes schools and communities that have successfully implemented drug abuse prevention programs and presents information on how drugs affect people and how parents and teachers can recognize when students are using drugs. A list of resources and organizations which parents, students, and educators can use to develop plans to stop drug use in schools is included. A free copy can be obtained by writing *Schools Without Drugs*, Pueblo, CO 81009, or by calling 1-800-624-0100 outside of the District of Columbia area and 732-4161 in the District.

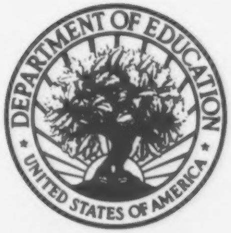
Ordering Information

To obtain individual copies of this book free of charge, please write:

Consumer Information Center
Dept. ED
Pueblo, CO 81009

To obtain more than 25 copies free of charge, please write:

Office of Public Affairs
Dept. ED
U.S. Department of Education
400 Maryland Avenue, S.W.
Washington, DC 20202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Supplement

MORBIDITY AND MORTALITY WEEKLY REPORT

Guidelines for Effective School Health Education To Prevent the Spread of AIDS

U.S. Department of Health and Human Services
Public Health Service
Centers for Disease Control
Center for Health Promotion and Education
Atlanta, Georgia 30333

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Guidelines for Effective School Health Education To Prevent the Spread of AIDS

Introduction

Since the first cases of acquired immunodeficiency syndrome (AIDS) were reported in the United States in 1981, the human immunodeficiency virus (HIV) that causes AIDS and other HIV-related diseases has precipitated an epidemic unprecedented in modern history. Because the virus is transmitted almost exclusively by behavior that individuals can modify, educational programs to influence relevant behavior can be effective in preventing the spread of HIV (*1-5*).

The guidelines below have been developed to help school personnel and others plan, implement, and evaluate educational efforts to prevent unnecessary morbidity and mortality associated with AIDS and other HIV-related illnesses. The guidelines incorporate principles for AIDS education that were developed by the President's Domestic Policy Council and approved by the President in 1987 (see Appendix I).

The guidelines provide information that should be considered by persons who are responsible for planning and implementing appropriate and effective strategies to teach young people about how to avoid HIV infection. These guidelines should not be construed as rules, but rather as a source of guidance. Although they specifically were developed to help **school personnel**, personnel from other organizations should consider these guidelines in planning and carrying out effective education about AIDS for youth who do **not** attend school and who may be at high risk of becoming infected. As they deliberate about the need for and content of AIDS education, educators, parents, and other concerned members of the community should consider the prevalence of behavior that increases the risk of HIV infection among young people in their communities. Information about the nature of the AIDS epidemic, and the extent to which young people engage in behavior that increases the risk of HIV infection, is presented in Appendix II.

Information contained in this document was developed by CDC in consultation with individuals appointed to represent the following organizations:

American Academy of Pediatrics
American Association of School Administrators
American Public Health Association
American School Health Association
Association for the Advancement of Health Education
Association of State and Territorial Health Officers
Council of Chief State School Officers
National Congress of Parents and Teachers
National Council of Churches

National Education Association
National School Boards Association
Society of State Directors of Health, Physical Education,
  Recreation and Dance
U.S. Department of Education
U.S. Food and Drug Administration
U.S. Office of Disease Prevention and Health Promotion

Consultants included a director of health education for a state department of education, a director of curriculum and instruction for a local education department, a health education teacher, a director of school health programs for a local school district, a director of a state health department, a deputy director of a local health department, and an expert in child and adolescent development.

Planning and Implementing Effective School Health Education about AIDS

The Nation's public and private schools have the capacity and responsibility to help assure that young people understand the nature of the AIDS epidemic and the specific actions they can take to prevent HIV infection, especially during their adolescence and young adulthood. The specific scope and content of AIDS education in schools should be locally determined and should be consistent with parental and community values.

Because AIDS is a fatal disease and because educating young people about becoming infected through sexual contact can be controversial, school systems should obtain broad community participation to ensure that school health education policies and programs to prevent the spread of AIDS are locally determined and are consistent with community values.

The development of school district policies on AIDS education can be an important first step in developing an AIDS education program. In each community, representatives of the school board, parents, school administrators and faculty, school health services, local medical societies, the local health department, students, minority groups, religious organizations, and other relevant organizations can be involved in developing policies for school health education to prevent the spread of AIDS. The process of policy development can enable these representatives to resolve various perspectives and opinions, to establish a commitment for implementing and maintaining AIDS education programs, and to establish standards for AIDS education program activities and materials. Many communities already have school health councils that include representatives from the aforementioned groups. Such councils facilitate the development of a broad base of community expertise and input, and they enhance the coordination of various activities within the comprehensive school health program (*6*).

AIDS education programs should be developed to address the needs and the developmental levels of students and of school-age youth who do not attend school, and to address specific needs of minorities, persons for whom English is not the primary language, and persons with visual or hearing impairments or other learning disabilities. Plans for addressing students' questions or concerns about AIDS at the early elementary grades, as well as for providing effective school health education about AIDS at each grade from late elementary/middle school through junior high/senior high school, including educational materials to be used, should be reviewed by representatives of the school board, appropriate school administrators, teachers, and parents before being implemented.

Education about AIDS may be most appropriate and effective when carried out within a more comprehensive school health education program that establishes a foundation for understanding the relationships between personal behavior and health (*7-9*). For example, education about AIDS may be more effective when students at appropriate ages are more knowledgeable about sexually transmitted diseases, drug abuse, and community health. It may also have greater impact when they have opportunities to develop such qualities as decision-making and communication skills, resistance to persuasion, and a sense of self-efficacy and self-esteem. However, education about AIDS should be provided as rapidly as possible, even if it is taught initially as a separate subject.

State departments of education and health should work together to help local departments of education and health throughout the state collaboratively accomplish effective school health education about AIDS. Although all schools in a state should provide effective education about AIDS, priority should be given to areas with the highest reported incidence of AIDS cases.

Preparation of Education Personnel

A team of representatives including the local school board, parent-teachers associations, school administrators, school physicians, school nurses, teachers, educational support personnel, school counselors, and other relevant school personnel should receive general training about a) the nature of the AIDS epidemic and means of controlling its spread, b) the role of the school in providing education to prevent transmission of HIV, c) methods and materials to accomplish effective programs of school health education about AIDS, and d) school policies for students and staff who may be infected. In addition, a team of school personnel responsible for teaching about AIDS should receive more specific training about AIDS education. All school personnel, especially those who teach about AIDS, periodically should receive continuing education about AIDS to assure that they have the most current information about means of controlling the epidemic, including up-to-date information about the most effective health education interventions available. State and local departments of education and health, as well as colleges of education, should assure that such in-service training is made available to all schools in the state as soon as possible and that continuing in-service and pre-service training is subsequently provided. The local school board should assure that release time is provided to enable school personnel to receive such in-service training.

Programs Taught by Qualified Teachers

In the elementary grades, students generally have one regular classroom teacher. In these grades, education about AIDS should be provided by the regular classroom teacher because that person ideally should be trained and experienced in child development, age-appropriate teaching methods, child health, and elementary health education methods and materials. In addition, the elementary teacher usually is sensitive to normal variations in child development and aptitudes within a class. In the secondary grades, students generally have a different teacher for each subject. In these grades, the secondary school health education teacher preferably should provide education about AIDS, because a qualified health education teacher will have training and experience in adolescent development, age-appropriate teaching methods, adolescent health, and secondary school health education methods and materials (including methods and materials for teaching about such topics as human sexuality, communicable diseases, and drug abuse). In secondary schools that do not have a qualified health education teacher, faculty with similar training and good rapport with students should be trained specifically to provide effective AIDS education.

Purpose of Effective Education about AIDS

The principal purpose of education about AIDS is to prevent HIV infection. The content of AIDS education should be developed with the active involvement of parents and should address the broad range of behavior exhibited by young people. Educational programs should assure that young people acquire the knowledge and skills they will need to adopt and maintain types of behavior that virtually eliminate their risk of becoming infected.

School systems should make programs available that will enable and encourage young people who **have not** engaged in sexual intercourse and who **have not** used illicit drugs to continue to—

- Abstain from sexual intercourse until they are ready to establish a mutually monogamous relationship within the context of marriage;
- Refrain from using or injecting illicit drugs.

For young people who **have** engaged in sexual intercourse or who **have** injected illicit drugs, school programs should enable and encourage them to—

- Stop engaging in sexual intercourse until they are ready to establish a mutually monogamous relationship within the context of marriage;
- To stop using or injecting illicit drugs.

Despite all efforts, some young people may remain unwilling to adopt behavior that would virtually eliminate their risk of becoming infected. Therefore, school systems, in consultation with parents and health officials, should provide AIDS education programs that address preventive types of behavior that should be practiced by persons with an increased risk of acquiring HIV infection. These include:

- Avoiding sexual intercourse with anyone who is known to be infected, who is at risk of being infected, or whose HIV infection status is not known;
- Using a latex condom with spermicide if they engage in sexual intercourse;
- Seeking treatment if addicted to illicit drugs;
- Not sharing needles or other injection equipment;
- Seeking HIV counseling and testing if HIV infection is suspected.

State and local education and health agencies should work together to assess the prevalence of these types of risk behavior, and their determinants, over time.

Content

Although information about the biology of the AIDS virus, the signs and symptoms of AIDS, and the social and economic costs of the epidemic might be of interest, such information is not the essential knowledge that students must acquire in order to prevent becoming infected with HIV. Similarly, a single film, lecture, or school assembly about AIDS will not be sufficient to assure that students develop the complex understanding and skills they will need to avoid becoming infected.

Schools should assure that students receive at least the essential information about AIDS, as summarized in sequence in the following pages, for each of three grade-level ranges. The exact grades at which students receive this essential information should be determined locally, in accord with community and parental values, and thus may vary from community to community. Because essential information for students at higher grades requires an understanding of information essential for students at lower grades, secondary school personnel will need to assure that students understand basic concepts before teaching more advanced information. Schools simultaneously should assure that students have opportunitites to learn about emotional and social factors that influence types of behavior associated with HIV transmission.

Early Elementary School

Education about AIDS for students in early elementary grades principally should be designed to allay excessive fears of the epidemic and of becoming infected.

AIDS is a disease that is causing some adults to get very sick, but it does not commonly affect children.

AIDS is very hard to get. You cannot get it just by being near or touching someone who has it.

Scientists all over the world are working hard to find a way to stop people from getting AIDS and to cure those who have it.

Late Elementary/Middle School

Education about AIDS for students in late elementary/middle school grades should be designed with consideration for the following information.

Viruses are living organisms too small to be seen by the unaided eye.

Viruses can be transmitted from an infected person to an uninfected person through various means.

Some viruses cause disease among people.

Persons who are infected with some viruses that cause disease may not have any signs or symptoms of disease.

AIDS (an abbreviation for acquired immunodeficiency syndrome) is caused by a virus that weakens the ability of infected individuals to fight off disease.

> *People who have AIDS often develop a rare type of severe pneumonia, a cancer called Kaposi's sarcoma, and certain other diseases that healthy people normally do not get.*
>
> *About 1 to 1.5 million of the total population of approximately 240 million Americans currently are infected with the AIDS virus and consequently are capable of infecting others.*
>
> *People who are infected with the AIDS virus live in every state in the United States and in most other countries of the world. Infected people live in cities as well as in suburbs, small towns, and rural areas. Although most infected people are adults, teenagers can also become infected. Females as well as males are infected. People of every race are infected, including whites, blacks, Hispanics, Native Americans, and Asian/Pacific Islanders.*
>
> *The AIDS virus can be transmitted by sexual contact with an infected person; by using needles and other injection equipment that an infected person has used; and from an infected mother to her infant before or during birth.*
>
> *A small number of doctors, nurses, and other medical personnel have been infected when they were directly exposed to infected blood.*
>
> *It sometimes takes several years after becoming infected with the AIDS virus before symptoms of the disease appear. Thus, people who are infected with the virus can infect other people—even though the people who transmit the infection do not feel or look sick.*
>
> *Most infected people who develop symptoms of AIDS only live about 2 years after their symptoms are diagnosed.*
>
> *The AIDS virus cannot be caught by touching someone who is infected, by being in the same room with an infected person, or by donating blood.*

Junior High/Senior High School

Education about AIDS for students in junior high/senior high school grades should be developed and presented taking into consideration the following information.

> *The virus that causes AIDS, and other health problems, is called human immunodeficiency virus, or HIV.*
>
> *The risk of becoming infected with HIV can be virtually eliminated by not engaging in sexual activities and by not using illegal intravenous drugs.*
>
> *Sexual transmission of HIV is not a threat to those uninfected individuals who engage in mutually monogamous sexual relations.*
>
> *HIV may be transmitted in any of the following ways: a) by sexual contact with an infected person (penis/vagina, penis/rectum, mouth/vagina, mouth/penis, mouth/rectum); b) by using needles or other injection equipment that an infected person has used; c) from an infected mother to her infant before or during birth.*
>
> *A small number of doctors, nurses, and other medical personnel have been infected when they were directly exposed to infected blood.*
>
> *The following are at increased risk of having the virus that causes AIDS and consequently of being infectious: a) persons with clinical or laboratory evidence of*

infection; b) males who have had sexual intercourse with other males; c) persons who have injected illegal drugs; d) persons who have had numerous sexual partners, including male or female prostitutes; e) persons who received blood clotting products before 1985; f) sex partners of infected persons or persons at increased risk; and g) infants born to infected mothers.

The risk of becoming infected is increased by having a sexual partner who is at increased risk of having contracted the AIDS virus (as identified previously), practicing sexual behavior that results in the exchange of body fluids (i.e., semen, vaginal secretions, blood), and using unsterile needles or paraphernalia to inject drugs.

Although no transmission from deep, open-mouth (i.e., "French") kissing has been documented, such kissing theoretically could transmit HIV from an infected to an uninfected person through direct exposure of mucous membranes to infected blood or saliva.

In the past, medical use of blood, such as transfusing blood and treating hemophiliacs with blood clotting products, has caused some people to become infected with HIV. However, since 1985 all donated blood has been tested to determine whether it is infected with HIV; moreover, all blood clotting products have been made from screened plasma and have been heated to destroy any HIV that might remain in the concentrate. Thus, the risk of becoming infected with HIV from blood transfusions and from blood clotting products is virtually eliminated. Cases of HIV infection caused by these medical uses of blood will continue to be diagnosed, however, among people who were infected by these means before 1985.

Persons who continue to engage in sexual intercourse with persons who are at increased risk or whose infection status is unknown should use a latex condom (not natural membrane) to reduce the likelihood of becoming infected. The latex condom must be applied properly and used from start to finish for every sexual act. Although a latex condom does not provide 100% protection—because it is possible for the condom to leak, break, or slip off—it provides the best protection for people who do not maintain a mutually monogamous relationship with an uninfected partner. Additional protection may be obtained by using spermicides that seem active against HIV and other sexually transmitted organisms in conjunction with condoms.

Behavior that prevents exposure to HIV also may prevent unintended pregnancies and exposure to the organisms that cause Chlamydia *infection, gonorrhea, herpes, human papillomavirus, and syphilis.*

Persons who believe they may be infected with the AIDS virus should take precautions not to infect others and to seek counseling and antibody testing to determine whether they are infected. If persons ***are not*** *infected, counseling and testing can relieve unnecessary anxiety and reinforce the need to adopt or continue practices that reduce the risk of infection. If persons* ***are*** *infected, they should: a) take precautions to protect sexual partners from becoming infected; b) advise previous and current sexual or drug-use partners to receive counseling and testing; c) take precautions against becoming pregnant; and d) seek medical care* *and counseling about other medical problems that may result from a weakened immunologic system.*

More detailed information about AIDS, including information about how to obtain counseling and testing for HIV, can be obtained by telephoning the AIDS National Hotline (toll free) at 800-342-2437; the Sexually Transmitted Diseases National Hotline (toll free) at 800-227-8922; or the appropriate state or local health department (the telephone number of which can be obtained by calling the local information operator).

Curriculum Time and Resources

Schools should allocate sufficient personnel time and resources to assure that policies and programs are developed and implemented with appropriate community involvement, curricula are well-planned and sequential, teachers are well-trained, and up-to-date teaching methods and materials about AIDS are available. In addition, it is crucial that sufficient classroom time be provided at **each** grade level to assure that students acquire essential knowledge appropriate for that grade level, and have time to ask questions and discuss issues raised by the information presented.

Program Assessment

The criteria recommended in the foregoing "Guidelines for Effective School Health Education To Prevent the Spread of AIDS" are summarized in the following nine assessment criteria. Local school boards and administrators can assess the extent to which their programs are consistent with these guidelines by determining the extent to which their programs meet each point shown below. Personnel in state departments of education and health also can use these criteria to monitor the extent to which schools in the state are providing effective health education about AIDS.

1. To what extent are parents, teachers, students, and appropriate community representatives involved in developing, implementing, and assessing AIDS education policies and programs?
2. To what extent is the program included as an important part of a more comprehensive school health education program?
3. To what extent is the program taught by regular classroom teachers in elementary grades and by qualified health education teachers or other similarly trained personnel in secondary grades?
4. To what extent is the program designed to help students acquire essential knowledge to prevent HIV infection at each appropriate grade?
5. To what extent does the program describe the benefits of abstinence for young people and mutually monogamous relationships within the context of marriage for adults?
6. To what extent is the program designed to help teenage students avoid specific types of behavior that increase the risk of becoming infected with HIV?
7. To what extent is adequate training about AIDS provided for school administrators, teachers, nurses, and counselors—especially those who teach about AIDS?

8. To what extent are sufficient program development time, classroom time, and educational materials provided for education about AIDS?
9. To what extent are the processes and outcomes of AIDS education being monitored and periodically assessed?

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3. US Department of Health and Human Services, Public Health Service. Surgeon General's report on acquired immune deficiency syndrome. Washington, DC: US Department of Health and Human Services, 1986.
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Appendix I

The President's Domestic Policy Council's Principles for AIDS Education

The following principles were proposed by the Domestic Policy Council and approved by the President in 1987:

> Despite intensive research efforts, prevention is the only effective AIDS control strategy at present. Thus, there should be an aggressive Federal effort in AIDS education.
>
> The scope and content of the school portion of this AIDS education effort should be locally determined and should be consistent with parental values.
>
> The Federal role should focus on developing and conveying accurate health information on AIDS to the educators and others, not mandating a specific school curriculum on this subject, and trusting the American people to use this information in a manner appropriate to their community's needs.
>
> Any health information developed by the Federal Government that will be used for education should encourage responsible sexual behavior—based on fidelity, commitment, and maturity, placing sexuality within the context of marriage.
>
> Any health information provided by the Federal Government that might be used in schools should teach that children should not engage in sex and should be used with the consent and involvement of parents.

Appendix II

The Extent of AIDS and Indicators of Adolescent Risk

Since the first cases of acquired immunodeficiency syndrome (AIDS) were reported in the United States in 1981, the human immunodeficiency virus (HIV) that causes AIDS and other HIV-related diseases has precipitated an epidemic unprecedented in modern history. Although in 1985, fewer than 60% of AIDS cases in the United States were reported among persons residing outside New York City and San Francisco, by 1991 more than 80% of the cases will be reported from other localities (*1*).

It has been estimated that from 1 to 1.5 million persons in the United States are infected with HIV (*1*), and, because there is no cure, infected persons are potentially capable of infecting others indefinitely. It has been predicted that 20%-30% of individuals currently infected will develop AIDS by the end of 1991 (*1*). Fifty percent of those diagnosed as having AIDS have not survived for more than about 1.5 years beyond diagnosis, and only about 12% have survived for more than 3 years (*2*).

By the end of 1987, about 50,000 persons in the United States had been diagnosed as having AIDS, and about 28,000 had died from the disease (*2*). Blacks and Hispanics, who make up about 12% and 6% of the U.S. population, respectively, disproportionately have contracted 25% and 14% of all reported AIDS cases (3). It has been estimated that during 1991, 74,000 cases of AIDS will be diagnosed, and 54,000 persons will die from the disease. By the end of that year, the total number of deaths caused by AIDS will be about 179,000 (1). In addition, health care and supportive services for the 145,000 persons projected to be living with AIDS in that year will cost our Nation an estimated $8-$10 billion in 1991 alone (1). The World Health Organization projects that by 1991, 50-100 million persons may be infected worldwide (4). The magnitude and seriousness of this epidemic requires a systematic and concerted response from almost every institution in our society.

A vaccine to prevent transmission of the virus is not expected to be developed before the next decade, and its use would not affect the number of persons already infected by that time. A safe and effective antiviral agent to treat those infected is not expected to be available for general use within the next several years. The Centers for Disease Control (5), the National Academy of Sciences (6), the Surgeon General of the United States (7), and the U.S. Department of Education (8) have noted that in the absence of a vaccine or therapy, educating individuals about actions they can take to protect themselves from becoming infected is the most effective means available for controlling the epidemic. Because the virus is transmitted almost exclusively as a result of behavior individuals can modify (e.g., by having sexual contact with an infected person or by sharing intravenous drug paraphernalia with an infected person), educational programs designed to influence relevant types of behavior can be effective in controlling the epidemic.

A significant number of teenagers engage in behavior that increases their risk of becoming infected with HIV. The percentage of metropolitan teenage girls who had ever had sexual intercourse increased from 30%-45% between 1971 and 1982. The average age at first intercourse for females remained at approximately 16.2 years between 1971 and 1979 (9). The average proportion of never-married teenagers who have ever had intercourse increases with age from 14 through 19 years. In 1982, the percentage of never-married girls who reported having engaged in sexual intercourse was as follows: approximately 6% among 14-year-olds (10), 18% among 15-year-olds, 29% among 16-year-olds, 40% among 17-year-olds, 54% among 18-year-olds, and 66% among 19-year-olds (11). Among never-married boys living in metropolitan areas, the percentage who reported having engaged in sexual intercourse was as follows: 24% among 14-year-olds, 35% among 15-year-olds, 45% among 16-year olds, 56% among 17-year-olds, 66% among 18-year olds, and 78% among 19-year olds (9,12). Rates of sexual experience (e.g., percentage having had intercourse) are higher for black teenagers than for white teenagers at every age and for both sexes (11,12).

Male homosexual intercourse is an important risk factor for HIV infection. In one survey conducted in 1973, 5% of 13- to 15-year-old boys and 17% of 16- to 19-year-old boys reported having had at least one homosexual experience. Of those who reported having had such an experience, most (56%) indicated that the first homosexual experience had occurred when they were 11 or 12 years old. Two percent reported that they currently engaged in homosexual activity (13).

Another indicator of high-risk behavior among teenagers is the number of cases of sexually transmitted diseases they contract. Approximately 2.5 million teenagers are affected with a sexually transmitted disease each year (14).

Some teenagers also are at risk of becoming infected with HIV through illicit intravenous drug use. Findings from a national survey conducted in 1986 of nearly 130 high schools indicated that although overall illicit drug use seems to be declining slowly among high school seniors, about 1% of seniors reported having used heroin and 13% reported having used cocaine within the previous year (*15*). The number of seniors who injected each of these drugs is not known.

Only 1% of all the persons diagnosed as having AIDS have been under age 20 (*2*); most persons in this group had been infected by transfusion or perinatal transmission. However, about 21% of all the persons diagnosed as having AIDS have been 20-29 years of age. Given the long incubation period between HIV infection and symptoms that lead to AIDS diagnosis (3 to 5 years or more), some fraction of those in the 20- to 29-year-age group diagnosed as having AIDS were probably infected while they were still teenagers.

Among military recruits screened in the period October 1985-December 1986, the HIV seroprevalence rate for persons 17-20 years of age (0.6/1,000) was about half the rate for recruits in all age groups (1.5/1,000) (*16*). These data have lead some to conclude that teenagers and young adults have an appreciable risk of infection and that the risk may be relatively constant and cumulative (*17*).

Reducing the risk of HIV infection among teenagers is important not only for their well-being but also for the children they might produce. The birth rate for U.S. teenagers is among the highest in the developed world (*18*); in 1984, this group accounted for more than 1 million pregnancies. During that year the rate of pregnancy among sexually active teenage girls 15-19 years of age was 233/1,000 girls (*19*).

Although teenagers are at risk of becoming infected with and transmitting the AIDS virus as they become sexually active, studies have shown that they do not believe they are likely to become infected (*20,21*). Indeed, a random sample of 860 teenagers (ages 16-19) in Massachusetts revealed that, although 70% reported they were sexually active (having sexual intercourse or other sexual contact), only 15% of this group reported changing their sexual behavior because of concern about contracting AIDS. Only 20% of those who changed their behavior selected effective methods such as abstinence or use of condoms (*20*). Most teenagers indicated that they want more information about AIDS (*20,21*).

Most adult Americans recognize the early age at which youth need to be advised about how to protect themselves from becoming infected with HIV and recognize that the schools can play an important role in providing such education. When asked in a November 1986 nationwide poll whether children should be taught about AIDS in school, 83% of Americans agreed, 10% disagreed, and 7% were not sure (*22*). According to information gathered by the United States Conference of Mayors in December of 1986, 40 of the Nation's 73 largest school districts were providing education about AIDS, and 24 more were planning such education (*23*). Of the districts that offered AIDS education, 63% provided it in 7th grade, 60% provided it in 9th grade, and 90% provided it in 10th grade. Ninety-eight percent provided medical facts about AIDS, 78% mentioned abstinence as a means of avoiding infection, and 70% addressed the issues of avoiding high-risk sexual activities, selecting sexual partners, and using condoms. Data collected by the National Association of State Boards of Education in the summer of 1987 indicated that a) 15 states had mandated comprehensive school health education; eight had mandated AIDS education; b) 12 had legislation pending on AIDS education, and six had state board of education actions pending; c) 17 had developed curricula for AIDS education, and seven more were developing such materials; and d) 40 had developed policies on admitting students with AIDS to school (*24*).

The Nation's system of public and private schools has a strategic role to play in assuring that young people understand the nature of the epidemic they face and the specific actions they can take to protect themselves from becoming infected—especially during their adolescence and young adulthood. In 1984, 98% of 14 and 15 year-olds, 92% of 16 and 17 year-olds, and 50% of 18 and 19 year-olds were in school (*25*). In that same year, about 615,000 14- to 17-year-olds and 1.1 million 18- to 19-year-olds were not enrolled in school and had not completed high school (*26*).

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Additional copies may be requested from the National AIDS Information Clearinghouse, "Guidelines for Effective School Health Education to Prevent the Spread of AIDS" P.O. Box 6003 Rockville, Maryland 20850.

☆U.S. G.P.O. 1988-532-350

NAIC
National AIDS Information Clearinghouse

U.S. Department of Health and Human Services
Public Health Service
Centers for Disease Control

NAIC Conference Calendar

July 1989

The National AIDS Information Clearinghouse (NAIC)

We're here to make things clear

NAIC is the central source to help you find AIDS- and HIV-related services and educational materials. The Centers for Disease Control operates the Clearinghouse to serve the information needs of AIDS professionals. Through the Clearinghouse you can:

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- **Locate** hard-to-find educational materials—brochures, pamphlets, State reports, posters, and audiovisuals—and learn how to get copies.
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NAIC's information specialists use databases and a variety of other resources to respond quickly and comprehensively to your telephone and written requests for information.

Until a cure is found, information and education are our only weapons to fight AIDS and HIV infection. With your involvement, we are confident that NAIC will reach its goal of fostering an effective exchange of helpful information and materials.

National AIDS Information Clearinghouse
P.O. Box 6003
Rockville, MD 20850
(301) 762-5111

The NAIC Conference Calendar

Your source for AIDS and HIV infection conference information

The National AIDS Information Clearinghouse (NAIC) Conference Calendar links you with upcoming events relating to AIDS and HIV infection. The monthly Conference Calendar helps you:

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- **Increase** attendance at your events. AIDS practitioners and policymakers read about your conference, seminar, or meeting in the Calendar. And the Calendar helps you schedule your event so it does not conflict with other presentations.
- **Establish** new networking contacts with representatives of AIDS service organizations.
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Visit our exhibit booth to talk to NAIC staff and pick up current information on AIDS and HIV infection. This is where you'll find us:

National Conference of State Legislators—Annual Meeting
August 6-11
Tulsa, OK

American Public Health Association—117th Annual Meeting
October 22-26
Chicago, IL

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National AIDS Information Clearinghouse (NAIC)

Conference Calendar

JULY

July 2-8

Tallahassee
FL

National Association of Black and White Men Together—9th Annual Convention

Sponsor: National Association of Black and White Men Together

Contact: BWMT Tallahassee/Big Bend Florida
411 Chapel Drive, Box 226
Tallahassee, FL 32304-3321
(904) 681-9499

July 6-7

Denver
CO

***HIV Serologic Test Counseling and Partner Notification Techniques**

Sponsors: Colorado Department of Health,
STD/AIDS Education and Training Program;
Centers for Disease Control

Contact: Gerrit Bakker
Colorado Department of Health
STD/AIDS Education and Training Program
4210 East 11th Avenue
Denver, CO 80220
(303) 331-8311

July 11

Pittsburgh
PA

***Ethical, Legal and Policy Issues: Professional and Institutional Responsibilities in Dealing With HIV Infection**

Sponsors: Pennsylvania/New York AIDS Regional Education and Training Center;
University of Pittsburgh, Graduate School of Public Health

Contact: Linda Frank-Hertweck
University of Pittsburgh
Graduate School of Public Health
207 F Parran Hall
Pittsburgh, PA 15261
(412) 624-1895

*Conferences added this period

July 11-12

Psychological Issues Related to HIV Testing

Cincinnati
OH

Sponsors: Cincinnati STD Prevention/Training Center;
Centers for Disease Control

Contact: Sandy Johnson
Cincinnati STD Prevention/Training Center
3101 Burnet Avenue
Cincinnati, OH 45229
(513) 352-3152

July 12

National Fellows Program AIDS Workshop

San Diego
CA

Sponsor: National Association of Elementary School Principals

Contact: Merrie Hahn
National Association of Elementary School Principals
1615 Duke Street
Alexandria, VA 22314
(703) 684-3345

July 12-14

STD-89: HIV Antibody Testing and Counseling

San Juan
Puerto Rico

Sponsors: Latin American STD Prevention/Training Center;
Centers for Disease Control

Contact: Latin American STD Prevention/Training Center
Call Box STD
Caparra Heights Station
San Juan, Puerto Rico 00922
(809) 765-1010

July 14-15

AIDS Community Training Conference

Portland
OR

Sponsor: American Psychological Association

Contact: Jeanie Kelleher
AIDS Community Training Project
1200 17th Street NW., Room 311
Washington, DC 20036
(202) 955-7740

July 15-19

Coalitions: Partnerships for Progress—1989 Annual Conference

Kansas City
MO

Sponsor: National Council of La Raza

Contact: Eileen Torres
National Council of La Raza
Conference Office
810 First Street NE., Third Floor
Washington, DC 20002
(202) 289-1380

July 15-20

Orlando
FL

*National Medical Association—Annual Convention and Scientific Assembly

Sponsor: National Medical Association

Contact:
William Garrett
National Medical Association
1012 Tenth Street NW.
Washington, DC 20001
(202) 347-1895

July 16-21

London
United Kingdom

International Conference on Health Law and Ethics—Second

Sponsor: American Society of Law and Medicine

Contact:
Lawrence O. Gostin
American Society of Law and Medicine
765 Commonwealth Avenue, Suite 1634
Boston, MA 02215
(617) 262-4990

July 16-21

Stevens Point
WI

*National Wellness Conference

Sponsor: National Wellness Institute

Contact:
Jane Fameree
National Wellness Institute
South Hall
1319 Fremont Street
Stevens Point, WI 54481
(715) 346-2172

July 16-22

Vienna
Austria

International Lesbian and Gay Association—Annual Meeting

Sponsor: International Lesbian and Gay Association

Contact:
Homosexuelle Initiative (HOST)
ILGA Conference Organizing Committee
Novaragasse 40
14-1020
Vienna, Austria

*Conferences added this period

July 17-19

Washington
DC

Public Health Conference on Records and Statistics—22d Biennial: Challenge for Public Health Statistics in the 1990's

Sponsor: National Center for Health Statistics

Contact:
Nancy Hamilton
National Center for Health Statistics
Office of Planning and Extramural Programs
Public Health Conference on Records and Statistics
3700 East-West Highway, Room 2-12
Hyattsville, MD 20782
(301) 436-7122

July 17-21

Seattle
WA

Changing Teens' Behavior Regarding Sex and AIDS

Sponsor: ETR Associates

Contact:
Bonnie Horn
ETR Associates
P.O. Box 1830
Santa Cruz, CA 95061
(408) 438-4060

July 17-21

Newton Center
MA

***Perspective on AIDS: Societal Challenges and Responses**

Sponsor: National Center for Death Education

Contact:
Beth Perdue
National Center for Death Education
Mount Ida College
777 Dedham Street
Newton Center, MA 02159
(617) 536-6970

July 18-20

Boston
MA

***Biotechnology in Public Health**

Sponsor: Harvard University, School of Public Health,
Office of Continuing Education

Contact:
Harvard University, School of Public Health
Office of Continuing Education
Department A
677 Huntington Avenue
Room L-23
Boston, MA 02115
(617) 732-1171

*Conferences added this period

July 19-20

Greenville
NC

*HIV Antibody Counseling and Testing Workshop—Advanced

Sponsor: North Carolina Department of Human Resources, Division of Health Services, AIDS Control Program

Contact: Elizabeth Randall-David
North Carolina Department of Human Resources
Division of Health Services, AIDS Control Program
P.O. Box 2091
Raleigh, NC 27602-2091
(919) 733-7301

July 23-27

Atlanta
GA

*American Association for Clinical Chemistry—41st National Meeting

Sponsor: American Association for Clinical Chemistry

Contact: American Association for Clinical Chemistry
2029 K Street NW., Seventh Floor
Washington, DC 20006
(202) 857-0717

July 23-28

Vallejo
CA

*Health Promotion Conference—Fourth Annual

Sponsor: California Department of Education

Contact: Rae Kine
California Department of Education
Health, Nutrition, and Physical Education Program
P.O. Box 944272
Sacramento, CA 94244-2720
(916) 322-5420

July 23-28

South Bend
IN

National Catholic AIDS Ministry Conference—Second

Sponsor: National Catholic AIDS Ministry

Contact: Jay Pinkerton
LAZZARO Center
P.O. Box 30926
New York, NY 10011
(212) 779-0450

July 23-August 11

Medford
MA

New England Epidemiology Summer Program—Ninth Annual

Sponsor: Tufts University, New England Epidemiology Institute

Contact: Tufts University
New England Epidemiology Institute
Department SC-15
P.O. Box 57
Chestnut Hill, MA 02167
(617) 734-9100

*Conferences added this period

July 24-25

***HIV Infection and AIDS: Train the Trainer**

Denver
CO

Sponsor: Colorado Department of Health,
STD/AIDS Education and Training Program

Contact: Patrick J. Barnett
Colorado Department of Health
STD/AIDS Education and Training Program
4210 East 11th Avenue
Denver, CO 80220
(303) 331-8311

July 27

***Psychosocial Implications of HIV Infection and AIDS**

Denver
CO

Sponsor: Colorado Department of Health,
STD/AIDS Education and Training Program

Contact: David Holbrook
Colorado Department of Health
STD/AIDS Education and Training Program
4210 East 11th Avenue
Denver, CO 80220
(303) 331-8311

July 27-28

HIV Testing and Counseling Clinical Rotation

Denver
CO

Sponsors: Denver STD Prevention/Training Center;
Centers for Disease Control

Contact: Teri Anderson
Denver STD Prevention/Training Center
605 Bannock Street
Denver, CO 80204
(303) 893-7191

July 31-August 4

Changing Teens' Behavior Regarding Sex and AIDS

Minneapolis
MN

See July 17-21 for Sponsor and Contact.

AUGUST

August 5-12

Fine Needle Biopsy Course—Ninth Annual Conference

Kauai
HI

Sponsor: University of California San Francisco, School of Medicine

Contact: University of California San Francisco, School of Medicine
Extended Programs in Medical Education
Room U-569
San Francisco, CA 94143-0742
(415) 476-4251

*Conferences added this period

August 6-11

Tulsa
OK

National Conference of State Legislators—Annual Meeting

Sponsor: National Conference of State Legislators

Contact: National Conference of State Legislators
1050 17th Street, Suite 2100
Denver, CO 80265
(303) 623-7800

August 7-11

Denver
CO

***AIDS Health Education, Planning, and Evaluation Training**

Sponsor: Colorado Department of Health,
STD/AIDS Education and Training Program

Contact: David Holbrook
Colorado Department of Health,
STD/AIDS Education and Training Program
4210 East 11th Avenue
Denver, CO 80220
(303) 331-8311

August 7-11

San Francisco
CA

***Changing Teens' Behavior Regarding Sex and AIDS**

See July 17-21 for Sponsor and Contact.

August 9-10

Greenville
NC

***HIV Antibody Counseling and Testing Workshop—Advanced**

See July 19-20 for Sponsor and Contact.

August 9-11

San Juan
Puerto Rico

STD-89: HIV Antibody Testing and Counseling

See July 12-14 for Sponsor and Contact.

August 11

Denver
CO

***HIV and Other STD's in Adolescents**

Sponsors: Denver STD Prevention/Training Center;
Centers for Disease Control

Contact: Teri Anderson
Denver STD Prevention/Training Center
605 Bannock Street
Denver, CO 80204
(303) 893-7191

*Conferences added this period
▨ NAIC will exhibit at this conference

August 11-15

New Orleans
LA

American Psychological Association—97th Annual Convention

Sponsor: American Psychological Association

Contact: Candy Won
American Psychological Association
1200 17th Street NW.
Washington, DC 20036
(202) 955-7600

August 13-17

Washington
DC

National Conference on HIV Infection and AIDS Among Racial and Ethnic Populations

Sponsors: A collaboration of United States Public Health Service agencies coordinated by the Office of Minority Health

Contact: Valerie P. Setlow
Minority AIDS Conference
Switzer Building, Room 1310
330 C Street SW.
Washington, DC 20201
(202) 245-6268

August 14-15

Minneapolis
MN

Community-Based Care for Persons with AIDS: Developing a Research Agenda

Sponsors: National Center for Health Services,
Research and Health Care Technology Assessment;
University of Minnesota, School of Medicine,
Continuing Medical Education

Contact: Barton W. Galle
University of Minnesota, School of Medicine
Continuing Medical Education
420 Delaware Street SE.
Minneapolis, MN 55455
(612) 626-5525

August 15-18

Washington
DC

***Emergency Health Care Development**

Sponsors: Medical Care Development International;
U.S. Public Health Service;
U.S. Department of Transportation;
World Health Organization

Contact: Medical Care Development International
1742 R Street NW.
Washington, DC 20009
(202) 462-1920

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*Conferences added this period

August 17-18

Haw River
NC

***HIV Antibody Counseling and Testing Workshop—Basic**

See July 19-20 for Sponsor and Contact.

August 17-18

Chicago
IL

STD-89: AIDS Update

Sponsors: Chicago STD Prevention/Training Center;
Centers for Disease Control

Contact: Marcia Brook
Chicago STD Prevention/Training Center
Municipal Social Hygiene Clinic
1306 South Michigan Avenue
Chicago, IL 60605
(312) 435-5422

August 17-19

Boston
MA

American Podiatric Medical Association—Annual Meeting

Sponsor: American Podiatric Medical Association

Contact: Conference Coordinator
American Podiatric Medical Association
9312 Old Georgetown Road
Bethesda, MD 20814-1621
(301) 571-9200

August 17-19

San Francisco
CA

***National Primary Care Conference**

Sponsor: Nurse Practitioner Associates for Continuing Education

Contact: Nurse Practitioner Associates for Continuing Education
5 Militia Drive
Lexington, MA 02173
(617) 861-0270

August 22-23

Denver
CO

***HIV Infection and AIDS: Train the Trainer**

See July 24-25 for Sponsor and Contact.

August 24

Denver
CO

***Psychological Implications of HIV Infection and AIDS**

See July 27 for Sponsor and Contact.

*Conferences added this period

August 24-27

Chicago
IL

International Conference of Gay and Lesbian Jews—11th

Sponsor: World Congress of Gay and Lesbian Jews

Contact:
Congregation Or Chadash
c/o Second Unitarian Church
Conference Planning Committee
656 West Barry
Chicago, IL 60657
(312) 248-9456

August 25-28

Mackinac Island
MI

Advances in the Management of Infectious Diseases

Sponsor: University of Michigan, Medical School

Contact:
Betty Phillips
University of Michigan, Medical School
Office of Continuing Medical Education
G1100 Towsley Center
Box 0201
Ann Arbor, MI 48109-0201
(313) 763-1400

August 27-
September 1

Caracas
Venezuela

Pan American Congress on AIDS

Sponsors:
World Health Organization;
Centers for Disease Control;
Pan American Organization of Infectious Diseases;
Fogarty International Center/National Institutes of Health;
Pan American Health Organization;

Contact:
Mario R. Escobar
Medical College of Virginia
P.O. Box 106–MCV Station
Richmond, VA 23298
(804) 786-0856

August 28-30

Stockholm
Sweden

International Conference on Blood-Borne Infections in the Workplace

Sponsors:
World Health Organization;
International Labor Organization;
Fogarty International Center/National Institutes of Health;
Nordic Council of Ministers

Contact:
Catherina Ostrom
Congrex AB
P.O. Box 5619
S-114 86
Stockholm, Sweden
01-46-8-723-42-30
Telex 169 49 Krecon S.

SEPTEMBER

September 6-8

HIV/AIDS Prevention in Your Community

Anchorage
AK

Sponsors: Seattle STD Prevention/Training Center;
Centers for Disease Control

Contact: Patti Simon
Seattle STD Prevention/Training Center
820 NE. 45th Street
Seattle, WA 98105
(206) 543-9750

September 6-8

***National AIDS Conference**

Bismarck
ND

Sponsor: Plains Indian Nations of North Dakota

Contact: Ila Lohnes
Devils Lake Sioux Tribe
Health Education
P.O. Box 300
Fort Totten, ND 58335
(701) 766-4236

September 6-8

National Pediatric AIDS Conference—Fifth Annual

Los Angeles
CA

Sponsor: Los Angeles Pediatric AIDS Network

Contact: Los Angeles Pediatric AIDS Network
c/o Public Health Foundation
13200 Crossroads Parkway North, Suite 135
City of Industry, CA 91746

September 6-8

STD-89: HIV Antibody Testing and Counseling

San Juan
Puerto Rico

See July 12-14 for Sponsor and Contact.

September 7-8

***HIV Serologic Test Counseling and Partner Notification Techniques**

Denver
CO

See July 6-7 for Sponsor and Contact.

September 8-13

International Conference on AIDS Education—Third

Nashville
TN

Sponsor: International Society for AIDS Education

Contact: Gene Copello
Vanderbilt University
CCC 5319 Medical Center, North
Nashville, TN 37232
(615) 322-2252

*Conferences added this period

September 10-13

Copenhagen
Denmark

International Society for Sexually Transmitted Diseases Research

Sponsor: International Society for Sexually Transmitted Diseases

Contact:
Dis Congress Service Copenhagen
48, Linde Alle
DK-2720
Copenhagen, Denmark
45 1 71 22 44

September 10-14

Freiburg
Germany

European Society of Pneumology—Eighth Congress, Joint Meeting With the European Pediatric Respiratory Society

Sponsors:
European Society of Pneumology;
European Pediatric Respiratory Society

Contact:
H. Matthys
Hugstetterstr. 55
D-7800 Freiburg, F.R. Germany
(0761) 2703805

September 10-16

Dar-es-Salaam
Tanzania

AIDS and Other Communications—International Conference

Sponsor:
Muhimbili Medical Centre,
Department of Medicine

Contact:
Secretary Apeca—AIDS Conference
Muhimbili Medical Centre
Department of Medicine
P.O. Box 65001
Dar-es-Salaam, Tanzania
(051) 27081-262

September 11-12

Birmingham
AL

STD-89: AIDS Education for Dental Professionals

Sponsors:
Birmingham STD Prevention/Training Center;
Centers for Disease Control

Contact:
Sarah Ferrell
Birmingham STD Prevention/Training Center
1400 Sixth Avenue South, Room 102
P.O. Box 2646
Birmingham, AL 35202
(205) 933-9110

September 11-14

Baltimore
MD

First Responders AIDS Awareness and Prevention

Sponsors:
Baltimore STD Prevention/Training Center;
Centers for Disease Control

Contact:
Sylvia Sherr
Baltimore STD Prevention/Training Center
303 East Fayette Street, Fifth Floor
Baltimore, MD 21202
(301) 396-4448

September 13-15

Darwin
Australia

International Union Against Venereal Diseases and Treponematoses—Sixth Regional Conference

Sponsor: International Union Against Veneral Diseases and Treponematoses

Contact: International Union Against Veneral Diseases and

Treponematoses

Darwin Conference Communicable Centre
P.O. Box 41096
Casuarina, NT 5792
Australia

September 14-15

Denver
CO

HIV Testing and Counseling Clinical Rotation

See July 27-28 for Sponsor and Contact.

September 15-16

Salt Lake City
UT

AIDS Community Training Conference

See July 14-15 for Sponsor and Contact.

September 15-16

Phoenix
AZ

***AIDS: Dimensions of Care, An Update for Health Professionals**

Sponsor: Arizona Department of Health Services

Contact: Beverly Gordon
Arizona Department of Health Services
3008 North Third Street
Phoenix, AZ 85012
(602) 255-1292

September 15-20

Miami Beach
FL

National Association of Community Health Centers Annual Convention and Community Health Institute—20th Convention

Sponsor: National Association of Community Health Centers

Contact: National Association of Community Health Centers
1330 New Hampshire Avenue NW., Suite 122
Washington, DC 20036
(202) 659-8008

September 17-20

Houston
TX

Interscience Conference on Antimicrobial Agents and Chemotherapy—29th

Sponsor: American Society for Microbiology

Contact: American Society for Microbiology
1913 Eye Street NW.
Washington, DC 20006
(202) 833-9680

*Conferences added this period

September 18

San Francisco
CA

Until the Last Breath: Women With AIDS

Sponsors:
The Langtry;
The Women's Foundation;
Lesbian Rights Project;
San Francisco NOW;
Northern California Women's Caucus for Art

Contact:
BREATH
460 40th Street
Oakland, CA 94609
(415) 655-7289

September 18-19

Denver
CO

***HIV Infection and AIDS: Train the Trainer**

See July 24-25 for Sponsor and Contact.

September 20-22

San Diego
CA

***National Conference on Chronic Disease Prevention and Control—Fourth: Implementing Effective Strategies**

Sponsors:
Centers for Disease Control;
Association of State and Territorial Health Officials

Contact:
Centers for Disease Control
Center for Chronic Disease Prevention and Health Promotion
Mailstop C07
Atlanta, GA 30333
(404) 639-2249

September 20-22

Birmingham
AL

STD-89: Management of the HIV-Infected Person

Sponsors:
Birmingham STD Prevention/Training Center;
Centers for Disease Control

Contact:
Sarah Ferrell
Birmingham STD Prevention/Training Center
1400 Sixth Avenue South, Room 102
Birmingham, AL 35202
(201) 933-9110

September 20-24

Cold Spring Harbor
NY

***Modern Approaches to New Vaccines Including Prevention of AIDS**

Sponsor:
Cold Spring Harbor Laboratory

Contact:
Cold Spring Harbor Laboratory
Meetings Office
Bungtown Road
Cold Spring Harbor, NY 11724
(516) 367-8346

*Conferences added this period

September 21

Denver
CO

*Psychosocial Implications of HIV Infection and AIDS

See July 27 for Sponsor and Contact.

September 21-22

Praha
Czechoslovakia

Hematology and the Transfusion Service—Trilateral Symposium of Czechoslovakia, The German Democratic Republic and Peoples Republic of Poland

Sponsor: Czechoslovak Medical Society

Contact:
J.E. Purkyne
Czechoslovak Medical Society
Conference Department
Vitezneho Unora 31
CS-120 26 Praha 2, Czechoslovakia
29 68 89

September 21-22

Denver
CO

*HIV Serologic Test Counseling With Risk Assessment

Sponsor: Colorado Department of Health, STD/AIDS Education and Training Program

Contact:
Gerrit Bakker
Colorado Department of Health
STD/AIDS Education and Training Program
4210 East 11th Avenue
Denver, CO 80220
(303) 331-8311

September 21-23

Amsterdam
Netherlands

Immunodermatology Symposium—Fourth

Contact:
QLT Convention Services
Keizersgracht 792
1017 ED
Amsterdam
Netherlands

September 24

East Elmhurst
NY

*HIV/AIDS Epidemic: A Challenge to Pharmacists

Sponsors: Long Island University, Arnold and Marie Schwartz College of Pharmacy and Health Sciences;
New York University, AIDS Regional Education and Training Center

Contact:
Robert Lanthos
Long Island University
Arnold and Marie Schwartz College of Pharmacy and Health Sciences
University Plaza
Brooklyn, NY 11201
(718) 403-1065

*Conferences added this period

September 26-28

Montreux
Switzerland

Montreux 1989 International Chemical Information Conference and Exhibition

Sponsor: Infonortics Ltd.

Contact: Montreux 1989 Conference
IBC Technical Services Ltd.
Bath House, 56 Holborn Viaduct
London EC1A 2EX
Great Britain

September 27

Yakima
WA

HIV/AIDS Program Evaluation

Sponsors: Seattle STD Prevention/Training Center;
Centers for Disease Control

Contact: Patti Simon
Seattle STD Prevention/Training Center
820 NE. 45th Street
Seattle, WA 98105
(206) 543-9750

September 27

Cincinnati
OH

Psychological Issues Related to HIV Testing

See July 11-12 for Sponsor and Contact.

September 27-28

Baltimore
MD

National Symposium on AIDS Prevention—Third

Sponsor: Health and Education Council

Contact: Don Nelinson
Health and Education Council
7201 Rossville Boulevard
Baltimore, MD 21237
(301) 686-3610

September 28-29

Haw River
NC

***HIV Antibody Counseling and Testing Workshop—Advanced**

See July 19-20 for Sponsor and Contact.

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*Conferences added this period

OCTOBER

October 4-5

Baltimore
MD

*AIDS: A Challenge to Primary Care

Sponsors: University of Maryland Baltimore, School of Nursing; Mid-Atlantic AIDS Regional Education and Training Center

Contact:
Barbara Byfield
University of Maryland Baltimore
School of Nursing
655 West Lombard Street
Room 502G
Baltimore, MD 21201

October 4-6

Montgomery
AL

*Alabama AIDS Symposium—Third Annual

Sponsor: Alabama Department of Public Health

Contact:
Joan Huffstutler
Alabama Department of Public Health
2451 Fillingim Street
Mobile, AL 36617
(205) 471-7322

October 4-6

Washington
DC

*American College of Epidemiology—Annual Meeting

Sponsor: American College of Epidemiology

Contact:
American College of Epidemiology
110 East Warren Avenue
Detroit, MI 48201
(313) 833-0710

October 5-6

Fayetteville
NC

*HIV Antibody Counseling and Testing Workshop—Basic

See July 19-20 for Sponsor and Contact.

October 11-13

Boston
MA

AIDS and Infectious Disease in the Workplace

Sponsors: Harvard School of Public Health, Office of Continuing Education; Harvard AIDS Institute

Contact:
Sharon Black
Harvard School of Public Health
Office of Continuing Education
677 Huntington Avenue
Boston, MA 02115
(617) 732-1171

*Conferences added this period

October 11-14

Lake Buena Vista
FL

Pediatric Infectious Disease Seminar—Fall Update

Sponsor: Lloyd Noland Hospital and Health Centers

Contact:
George M. Converse
701 Lloyd Noland Parkway
Fairfield, AL 35604
(205) 783-5276

October 12-13

Boston
MA

History and Current Status of Institutional Review Boards: Current Retrospective Planner

Sponsors:
Public Responsibility in Medicine and Research;
Tufts University, School of Medicine

Contact:
Public Responsibility in Medicine and Research
132 Boylston Street, Fourth Floor
Boston, MA 02116
(617) 423-4112

October 16

New York
NY

International Consultation on HIV-Related Disease and Its Impact on Food Production, Nutrition, and Related Issues

Sponsors: Various international and intergovernmental agencies involved with AIDS, food and nutrition, and international development

Contact:
George M. Worthington
345 West 21st Street, #3D
New York, NY 10011
(212) 243-5883

October 18-20

Birmingham
AL

STD-89: First Responders AIDS Awareness and Prevention

Sponsors:
Birmingham STD Prevention/Training Center;
Centers for Disease Control

Contact:
Sarah Ferrell
Birmingham STD Prevention/Training Center
1400 Sixth Avenue South, Room 102
P.O. Box 2646
Birmingham, AL 35202
(202) 933-9110

October 18-20

San Juan
Puerto Rico

STD-89: HIV Antibody Testing and Counseling

See July 12-14 for Sponsor and Contact.

FOLD, STAPLE, OR TAPE AND MAIL

PLACE
STAMP
HERE

TO: Conference Calendar Information
National AIDS Information Clearinghouse
P.O. Box 6003
Rockville, MD 20850

Conference Calendar Subscription Request

Please begin my free subscription to the NAIC Conference Calendar.

Name____

Representing____________________ Title____________________

Address____

City____________________ State/Province____________________

ZIP/Postal Code____________________ Country____________________

Telephone (____) ____________________

____ Check here if you would like to receive more information about NAIC services.

Conference Information

Please supply the information requested below about your upcoming conference, training session, seminar, workshop, or other meeting of interest to AIDS and HIV-infection professionals.

This form must be returned to NAIC at least 6 weeks before the event. Please enclose a conference brochure or information packet if available. Appropriate events will be included in the Calendar as space allows.

Conference Name:__________

Beginning Date__________ **Ending Date**__________

Sponsoring Agency(ies):

Name of Agency__________
Department__________
Contact Person__________ Title__________
Street Address__________ City__________
State/Province__________ ZIP/Postal Code__________
Country__________ Telephone ( ) _____ Ext._____

Name of Agency__________
Department__________
Contact Person__________ Title__________
Street Address__________ City__________
State/Province__________ ZIP/Postal Code__________
Country__________ Telephone ( ) _____ Ext._____

Conference Location:

Hotel/Conference Center__________
Street Address__________ City__________
State/Province__________ ZIP/Postal Code__________
Country__________ Telephone ( ) _____ Ext._____

Other Information:

Target Audience__________
Estimated Number of Attendees__________
Registration Fee: Member__________ Nonmember__________

FOLD, STAPLE, OR TAPE AND MAIL

PLACE
STAMP
HERE

TO: Conference Calendar Information
National AIDS Information Clearinghouse
P.O. Box 6003
Rockville, MD 20850

October 19-20

Kansas City
MO

Challenging AIDS in the 1990's

Sponsors:
Missouri Department of Health;
Midwest AIDS Training Education Center

Contact:
Ken Steiner
University of Missouri
Office of Continuing Education
MA215 Health Sciences Center
Columbia, MO 65212
(314) 882-4106

October 19-20

Marseilles
France

International Conference on AIDS and Associated Cancers in Africa—Fourth

Sponsor:
Retroviruses and Associated Diseases Research Laboratory

Contact:
Christian DeVaux
Retroviruses and Associated Diseases Research Laboratory
Inserm U. 322 B.P. 33
Marseilles Cedex 9
France

October 19-21

Columbus
OH

AIDS in Ohio's Black and Hispanic Communities

Sponsor:
Ohio Department of Health, AIDS Activities Unit

Contact:
Rachelle Randolph
Ohio Department of Health
246 North High Street
Columbus, OH 43266
(614) 466-5480

October 20-23

Detroit
MI

Parents and Friends of Lesbians and Gays—Eighth Annual Conference

Sponsors:
Parents and Friends of Lesbians and Gays, Detroit Chapter;
Palmer Fund;
Forum Foundation

Contact:
Harriet Dart
P-FLAG/Detroit Chapter
P.O. Box 145
Farmington, MI 48332
(202) 638-4200
(313) 478-8408

October 21

San Diego
CA

*Inflammatory Bowel Disease—New Advances

Sponsor: National Foundation for Ileitis and Colitis,
Greater San Francisco Chapter

Contact: Nomi Feldman
P.O. Box 210211
San Diego, CA 92121
(619) 453-6222

October 21-26

New Orleans
LA

American Association of Blood Banks—42d Annual Meeting

Sponsor: American Association of Blood Banks

Contact: American Association of Blood Banks
1117 North 19th Street, Suite 600
Arlington, VA 22209
(703) 528-8200

October 22-26

Chicago
IL

American Public Health Association—117th Annual Meeting

Sponsor: American Public Health Association

Contact: Bob Johnson
American Public Health Association
1015 15th Street NW.
Washington, DC 20005
(202) 789-5672

October 22-26

Yaoundé
Cameroon

*International Symposium on AIDS Information and Education—Second

Sponsors: Government of Cameroon;
World Health Organization;
United Nations Educational Scientific and Cultural Organization

Contact: Yaoundé Symposium 89
B.P. 155
Yaoundé, Cameroon
(237) 22-29-20

October 23-24

Denver
CO

*HIV Infection and AIDS: Train the Trainer

See July 24-25 for Sponsor and Contact.

*Conferences added this period
▨NAIC will exhibit at this conference

October 23-25

Birmingham
AL

STD-89: Management of the HIV-Infected Person

See September 20-22 for Sponsor and Contact.

October 26

New York
NY

***Challenge of AIDS for Health Care Professionals—Third Annual Conference**

Sponsor: New York University, AIDS Mental Health Project

Contact:
William Sakolsky
New York University
AIDS Projects
Shimkin Hall, Room 532
50 West Fourth Street
New York, NY 10003
(212) 998-5332

October 26

Denver
CO

***Psychosocial Implications of HIV Infection and AIDS**

See July 27 for Sponsor and Contact.

October 26-28

Cincinnati
OH

***Our Church Has AIDS National Conference: Responding to AIDS—The Church as Prophet, Servant, and Teacher**

Sponsor: National Episcopal AIDS Coalition

Contact:
Sue Scott
National Episcopal AIDS Coalition
P.O. Box 550275
Dallas, TX 75355
(214) 343-6936

October 26-29

Las Vegas
NV

***Academy of Psychosomatic Medicine—36th Annual Meeting**

Sponsor: Academy of Psychosomatic Medicine

Contact:
Troy L. Thompson
Academy of Psychosomatic Medicine
5824 North Magnolia
Chicago, IL 60660
(312) 784-2025

October 30-November 3

Boston
MA

Diseases of the Chest—16th World Congress and 55th Annual Scientific Assembly

Sponsors: American College of Chest Physicians;
International Academy of Chest Physicians and Surgeons

Contact:
American College of Chest Physicians
Division of Education
911 Busse Highway
Park Ridge, IL 60068
(312) 698-2200

*Conferences added this period

NOVEMBER

November 1-3
Honolulu
HI

American Association of Public Health Dentistry—52d Annual Meeting

Sponsor: American Association of Public Health Dentistry

Contact:
E. Joseph Alderman
American Association of Public Health Dentistry
878 Peachtree Street NE., Room 215
Atlanta, GA 30309

November 1-3
Spokane
WA

HIV/AIDS Prevention in Your Community

See September 6-8 for Sponsor and Contact.

November 1-3
New York
NY

National Conference on AIDS Prevention, Education, and Service Delivery to People with Disabilities—First

Sponsors: Various national and local AIDS service providers and rehabilitation agencies/organizations

Contact:
George M. Worthington
345 West 21st Street, #3D
New York, NY 10011
(212) 243-5883

November 2-3
Columbus
OH

Fall Task Force Conference

Sponsor: Ohio Department of Health, AIDS Activities Unit

Contact:
Rachelle Randolph
Ohio Department of Health
AIDS Activities Unit
246 North High Street
Columbus, OH 43266
(614) 466-5480

November 2-3
Denver
CO

***HIV Serologic Test Counseling and Partner Notification Techniques**

See July 6-7 for Sponsor and Contact.

November 2-5
Washington
DC

National AIDS Network Skills Building Conference—Second

Sponsor: National AIDS Network

Contact:
Lynne G. Vance
National AIDS Network
2033 M Street NW., Suite 800
Washington, DC 20036
(202) 293-AIDS

*Conferences added this period

November 6-7

Birmingham
AL

STD-89: AIDS Education for Dental Professionals

See September 11-12 for Sponsor and Contact.

November 9-10

Atlanta
GA

***AIDS in the Minority Community—New Strategies for Case Management**

Sponsor: Morehouse School of Medicine, Area Health Education Center, AIDS Education Training Center

Contact:
Tina Marrow
Morehouse School of Medicine, Area Health Education Center
AIDS Education Training Center
720 Westview Drive SW.
Atlanta, GA 30310
(404) 752-1924

November 9-11

Chicago
IL

***National Conference on Correctional Health Care—13th**

Sponsor: National Commission on Correctional Health Care

Contact:
Edward A. Harrison
National Commission on Correctional Health Care
2000 North Racine
Chicago, IL 60614
(312) 528-0818

November 11

Amsterdam
Netherlands

World AIDS Congress

Sponsor: World AIDS Congress

Contact:
World AIDS Congress
P.O. Box 297
NL-2501 BD Den Haag, Netherlands
(070) 814481

November 12-16

Jerusalem
Israel

International Conference on Cryptococcus and Cryptococcosis

Contact:
Melia-Teum
P.O. Box 8388
Jerusalem 90082
Israel
02-6675402 or 02-637572

November 13-17

Denver
CO

***AIDS Health Education, Planning, and Evaluation Training**

See August 7-11 for Sponsor and Contact.

*Conferences added this period

November 13-17

Indianapolis
IN

Sigma Theta Tau International—30th Biennial Convention and Exhibition

Sponsor: Sigma Theta Tau International Honor Society of Nursing

Contact:
Sigma Theta Tau International
1200 Waterway Boulevard
Indianapolis, IN 46202
(317) 634-8171

November 13-19

New Orleans
LA

***National Student Nurses Association—Mid-Year Conference**

Sponsor: National Student Nurses Association

Contact:
Mary Belmont
National Student Nurses Association
555 West 57th Street
New York, NY 10019
(212) 581-2211

November 15-16

Dallas
TX

Conference for Nurses in AIDS Care—Second Annual

Sponsors: Association of Nurses in AIDS Care;
Health and Education Council

Contact:
Nancy McCaslin
Health and Education Council
7201 Rossville Boulevard
Baltimore, MD 21237
(301) 686-3610

November 15-17

Birmingham
AL

STD-89: First Responders AIDS Awareness and Prevention

See October 18-20 for Sponsor and Contact.

November 16-17

Fayetteville
NC

***HIV Antibody Counseling and Testing Workshop—Advanced**

See July 19-20 for Sponsor and Contact.

November 16-17

Denver
CO

HIV Testing and Counseling Clinical Rotation

See July 27-28 for Sponsor and Contact.

*Conferences added this period

November 17-18

Rotterdam
Netherlands

Sexually Transmitted Diseases: Viral Infections as Cause of STD—International Congress

Sponsor: Erasmus University, Office for Post Graduate Medical Education

Contact:
Erasmus University
Head Office for Post Graduate Medical Education
P.O. Box 1738
NL-3000 Dr Rotterdam, Netherlands
(010) 408 7880

November 19-21

Washington
DC

National Forum on AIDS and Hepatitis B—Fourth: Targets of Opportunity, Strategies for Control

Sponsor: National Foundation for Infectious Diseases

Contact:
William Small
National Foundation for Infectious Diseases
4733 Bethesda Avenue, Suite 750
Bethesda, MD 20814
(301) 656-0003

November 21-22

Denver
CO

***HIV Infection and AIDS: Train the Trainer**

See July 24-25 for Sponsor and Contact.

November 21-22

Cincinnati
OH

Psychological Issues Related to HIV Testing

See July 11-12 for Sponsor and Contact.

November 29

Denver
CO

***Psychosocial Implications of HIV Infection and AIDS**

See July 27 for Sponsor and Contact.

DECEMBER

December 2-5

Atlanta
GA

American Society of Hematology—Annual Meeting

Sponsor: American Society of Hematology

Contact:
Margaret Smith
Slack, Incorporated
6900 Grove Road
Thorofare, NJ 08086
(609) 848-1000

*Conferences added this period

December 4-6 **Newark** **NJ**	**STD-89: Clinical Management of AIDS**		
	Sponsors:	Newark STD Prevention/Training Center; Centers for Disease Control	
	Contact:	Newark STD Prevention/Training Center 110 Williams Street Newark, NJ 07102 (201) 643-0666	
December 11-12 **Denver** **CO**	***HIV Infection and AIDS: Train the Trainer**		
	See July 24-25 for Sponsor and Contact.		
December 11-12 **Birmingham** **AL**	**Physicians' AIDS Update**		
	Sponsors:	Birmingham STD Prevention/Training Center; Centers for Disease Control	
	Contact:	Sarah Ferrell Birmingham STD Prevention/Training Center 1400 Sixth Avenue South, Room 102 P.O. Box 2646 Birmingham, AL 35202 (205) 933-9110	
December 14-15 **Denver** **CO**	***HIV Serologic Test Counseling With Risk Assessment**		
	See September 21-22 for Sponsor and Contact.		

1990

February 21-24 **Miami** **FL**	***National Forum on AIDS and Chemical Dependency—Fourth**	
	Sponsor:	American Medical Society on Alcoholism and Other Drug Dependencies
	Contact:	American Medical Society on Alcoholism and Other Drug Dependencies 12 West 21st Street New York, NY 10010 (212) 206-6770

*Conferences added this period

March 14-18

San Francisco
CA

*National Hispanic Conference on Health and Human Services

Sponsor: National Coalition of Hispanic Health and Human Services Organizations

Contact:
National Coalition of Hispanic Health and Human Services Organizations
1030 15th Street NW., Suite 1053
Washington, DC 20005
(202) 371-2100

May 9-10

London
United Kingdom

*Sexually Transmitted Diseases in the World of AIDS

Sponsor: Royal Society of Medicine

Contact:
B. Komoniewska
Royal Society of Medicine
1 Wimpole Street
London W1M 8AE
United Kingdom

May 13-18

Anaheim
CA

*American Society for Clinical Microbiology—90th Annual Meeting

Sponsor: American Society for Clinical Microbiology

Contact:
American Society for Clinical Microbiology
1913 I Street NW.
Washington, DC 20006
(202) 833-9680

May 20-24

Boston
MA

*World Conference on Lung Health

Sponsors:
American Lung Association;
American Thoracic Society;
International Union Against Tuberculosis and Lung Disease

Contact:
American Lung Association/American Thoracic Society
1740 Broadway
New York, NY 10019
(212) 315-8700

*Conferences added this period

June 19-23

San Francisco
CA

***International Conference on AIDS—Sixth**

Sponsors:
University of California San Francisco;
City and County of San Francisco;
World Health Organization;
International AIDS Society

Contact:
P. Volberding
San Francisco General Hospital
San Francisco, CA 94110
(415) 550-0880

or

Conference Secretariat
655 15th Street NW.
Suite 300
Washington, DC 20005
(202) 639-5179

*Conferences added this period

Sponsor Index

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